SERFF Tracking Number:	*AFLA-125856287*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*40777*
Company Tracking Number:	*A72000*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Lump Sum Critical Illness*		
Project Name/Number:	*Lump Sum Critical Illness & Lump Sum Cancer/*		

Filing at a Glance

Company: American Family Life Assurance Company of Columbus

Product Name: Lump Sum Critical Illness	SERFF Tr Num: AFLA-125856287	State: ArkansasLH
TOI: H07I Individual Health - Specified Disease - Limited Benefit	SERFF Status: Closed	State Tr Num: 40777
Sub-TOI: H07I.001 Critical Illness	Co Tr Num: A72000	State Status: Approved-Closed
Filing Type: Form/Rate	Co Status:	Reviewer(s): Rosalind Minor
	Author: Connie Gates	Disposition Date: 02/10/2009
	Date Submitted: 11/05/2008	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Lump Sum Critical Illness & Lump Sum Cancer	Status of Filing in Domicile: Authorized
Project Number:	Date Approved in Domicile: 10/03/2008
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 02/10/2009	Explanation for Other Group Market Type:
	State Status Changed: 02/10/2009
Deemer Date:	Corresponding Filing Tracking Number:

Filing Description:

RE: Lump Sum Critical Illness Policy Form A72100AR, Lump Sum Cancer Benefit Rider Form A72050, Return of Premium Benefit Rider Form A72051, and Sudden Cardiac Death Benefit Rider Form A72052, Application Forms A72PAPPAR, A72GAPPAR, and A72UAPPAR, Underwriting Application Forms LSCI and LSCIG, Signature Forms AsignAR and AsigncAR, Request for Additions/Application for Reinstatement Forms A72003AR and A72003GAR,

SERFF Tracking Number:	*AFLA-125856287*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*40777*
Company Tracking Number:	*A72000*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Lump Sum Critical Illness*		
Project Name/Number:	*Lump Sum Critical Illness & Lump Sum Cancer/*		

Outline of Coverage Form A72125.

Lump Sum Cancer Policy Form A72200AR, Application Forms A72PCAPPAR, A72GCAPPAR, and A72UCAPPAR, Underwriting Application Forms LSCA and LSCAG, Outline of Coverage Form A72225.

Dear Mr. Musgrove:

Referenced forms are submitted for your review and approval. Nebraska, our state of domicile, has approved similar versions of these forms on October 3, 2008.

Lump Sum Critical Illness Policy Form A72100AR provides benefits for major critical illness events. Eligible critical illness events include Heart Attack, Stroke, End-Stage Renal Failure, Coma, Paralysis, and Major Human Organ Transplant occurring after the Effective Date of coverage. The Major Critical Illness Event Benefit may become payable again if the insured is free of any critical illness event, hospitalization or surgery due to a critical illness event for five years.

The Subsequent Critical Illness Event benefit will be paid at $5,000 for each covered person. These events must be separated by 180 days. The policy also provides a Coronary Artery Bypass Graft Surgery benefit and this benefit is independent of the 180 day separation period.

Lump Sum Cancer Policy Form A72200AR pays a lump sum when the insured is diagnosed with Internal Cancer. The policy also provides a Carcinoma In Situ Benefit that pays $2,000 upon a covered person’s onset date of Carcinoma In Situ. There is also a benefit for cancer related death that pays $5,000 when a covered person suffers a cancer related death. These events must be separated by 180 days.

The policies will be marketed to applicant's age 18 through 70 on a payroll, union, or large account basis. Coverage will terminate on the policy anniversary date after the policyholder’s 75th birthday. The same applies to the spouse if covered.

Lump Sum Cancer Benefit Rider Form A72050 provides benefits for Cancer only. This rider is only available with Lump

Sum Critical Illness Policy Form A72100AR. If the Lump Sum Cancer Benefit Rider is purchased on the Lump Sum Critical Illness policy, the Cancer benefits will be paid independently of the base. However, all covered Cancer benefits as identified in the rider must be separated by 180 days in order to receive payment.

Return of Premium Benefit Rider Form A72051 provides for a maximum refund of premiums paid if both the policy and rider remain in force for 20 consecutive years. This rider is available with Lump Sum Critical Illness Policy Form A72100AR and Lump Sum Cancer Policy Form A72200AR.

Sudden Cardiac Death Benefit Rider Form A72052 provides benefits in the event an insured dies due to sudden cardiac arrest. This rider is only available with Lump Sum Critical Illness Policy Form A72100AR.

The following forms will be used to apply for coverage as follows:

APPLICATION UW (underwriting) POLICY RIDERS

Payroll Application Form A72PAPPAR LSCI A72100AR A72050, and A72052
Payroll Cancer Application A72PCAPPAR LSCA A72200AR A72051
Large Account Application A72GAPPAR LSCIG A72100AR A72050, and A72052
Large Account Cancer Application Form A72GCAPPAR LSCAG A72200AR A72051
Union Application A72UAPPAR LSCI A72100AR A72050, and A72052
Union Cancer Application A72UCAPPAR LSCA A72200AR A72051

Application Forms A72PAPPAR, A72GAPPAR, A72UAPPAR, A72PCAPPAR, A72GCAPPAR, and A72UCAPPAR will be used to collect the personal information and select the type of coverage desired. Underwriting Forms LSCI, LSCA, LSCIG, and LSCAG will be used to answer the underwriting questions. Forms AsigncAR and AsignAR will be used to collect the applicant's and agent's signature. These forms differ in that Form AsigncAR contains an agent's certification statement. Form AsignAR does NOT contain the agent's certification statement and will be used in situations where the associate/agent is unable to be present at the time of application. When the final application prints and is attached to the policy at the time of issue, the application form, the underwriting form, and a signature page will be combined to reflect a complete application.

SERFF Tracking Number:	*AFLA-125856287*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*40777*
Company Tracking Number:	*A72000*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Lump Sum Critical Illness*		
Project Name/Number:	*Lump Sum Critical Illness & Lump Sum Cancer/*		

Brackets are included around the “Check Coverage Desired” section in all applicable application forms to allow us to change the coverage offered if needed. For example, if one of our accounts requests a specific “coverage package” we would be able to adjust the coverage desired section to accommodate their requests.

Reinstatement Application Forms A72003AR and A72003GAR will be used to reinstate a lapsed policy. Form A72003AR will be used for reinstatement of policies on a payroll or union basis and Form A72003GAR will be used to reinstate a lapsed policy on a large account.

Outline of Coverage Forms A72125 and A72225 will be delivered at the time of application and are self-explanatory. Outline of Coverage Form A72125 will be used with Policy Form A72100AR and Outline of Coverage Form A72225 will be used with Policy Form A72200AR.

I certify that the forms submitted herewith meet the applicable provisions of Rule and Regulation 18 of the Arkansas Insurance Department Regulations as well as meeting the applicable requirements of Arkansas Insurance Department.

I certify the following form complies with the requirements of Rule and Regulation 49 of the Arkansas Insurance Department Regulations, Life and Disability Guaranty Fund Notices.

This is to certify that the following forms comply with the requirements of Arkansas Statute Annotated Sections 23-80-201 through 23-80-208, cited as the Life and Disability Insurance Policy Language Simplification Act.

I certify that the enclosed forms meet the minimum reading ease score for the FLESCH test. I further certify the scores for each form are as follows:

FLESCH Score Grade Level
Policy Form A72100AR 50.000 10
Policy Form A72200AR 50.548 10
Rider Form A72050 79.209 4

SERFF Tracking Number:	*AFLA-125856287*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*40777*
Company Tracking Number:	*A72000*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Lump Sum Critical Illness*		
Project Name/Number:	*Lump Sum Critical Illness & Lump Sum Cancer/*		

Rider Form A72051 97.705 1

Rider Form A72052 96.279 1

Payroll Application Form A72PAPPAR 46.438 11

Payroll Application From A72PCAPPAR 61.033 7

Union Application Form A72UAPPAR 62.272 7

Union Application Form A72UCAPPAR 59.131 8

Large Account Application A72GAPPAR 60.005 7

Large Account Application A72GCAPPAR 62.869 7

Underwriting Application Form LSCI 64.983 6

Underwriting Application Form LSCIG 73.386 6

Underwriting Application Form LSCA 70.804 5

Underwriting Application Form LSCAG 69.255 5

Reinstatement Application Form A72003AR 75.695 4

Reinstatement Application Form A72003GAR 71.189 5

Signature Form AsignAR 66.891 7

Signature Form AsigncAR 74.252 4

Outline of Coverage Form A72125 62.659 6

Outline of Coverage Form A72225 69.610 5

An actuarial memorandum and rate sheets are enclosed for your review and approval. The appropriate filing fee and/or certification form are also included.

Aflac reserves the right to alter the format of the forms without re-filing due to future technology changes, i.e. paper size, font, font type, line ending or page ending changes. Be assured that any minimum font-size requirements will be met. Any changes to wording or content would be filed for prior approval. We have included brackets in all forms around the address, telephone number, web site, and officer signatures in the event these change in the future. We also reserve the right to use these forms in an electronic format, but Aflac certifies we will retain the filed final print format.

This filing has been prepared by Connie Gates. Should you have any questions or comments concerning this submission, please do not hesitate to call her collect at (706) 596-5048, by fax at (706) 660-7080 or email at

SERFF Tracking Number:	*AFLA-125856287*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*40777*
Company Tracking Number:	*A72000*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Lump Sum Critical Illness*		
Project Name/Number:	*Lump Sum Critical Illness & Lump Sum Cancer/*		

cgates@aflac.com.

Company and Contact

Filing Contact Information

Connie Gates, Policy Analyst	cgates@aflac.com
1932 Wynnton Road	(706) 596-5048 [Phone]
Columbus, GA 31999	(706) 660-7080[FAX]

Filing Company Information

American Family Life Assurance Company of Columbus	CoCode: 60380	State of Domicile: Nebraska
1932 Wynnton Road	Group Code:	Company Type: Life and Health
Columbus, GA 31999	Group Name:	State ID Number:
(706) 323-3431 ext. [Phone]	FEIN Number: 58-0663085	

Filing Fees

Fee Required?	Yes
Fee Amount:	$530.00
Retaliatory?	No
Fee Explanation:	2 Policies $100 19 forms $380 1 set of rates $50
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Family Life Assurance Company of Columbus	$530.00	11/05/2008	23720264

SERFF Tracking Number:	*AFLA-125856287*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*40777*
Company Tracking Number:	*A72000*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Lump Sum Critical Illness*		
Project Name/Number:	*Lump Sum Critical Illness & Lump Sum Cancer/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/10/2009	02/10/2009
Approved-Closed	Rosalind Minor	02/02/2009	02/02/2009

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	11/06/2008	11/06/2008	Connie Gates	01/30/2009	01/30/2009
Pending Industry Response	Rosalind Minor	11/06/2008	11/06/2008	Connie Gates	01/30/2009	01/30/2009
Pending Industry Response	Rosalind Minor	11/06/2008	11/06/2008	Connie Gates	01/30/2009	01/30/2009

Amendments

Item	Schedule	Created By	Created On	Date Submitted
Signature Form	Form	Connie Gates	02/10/2009	02/10/2009

SERFF Tracking Number:	*AFLA-125856287*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*40777*
Company Tracking Number:	*A72000*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Lump Sum Critical Illness*		
Project Name/Number:	*Lump Sum Critical Illness & Lump Sum Cancer/*		

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Request for Extension	Note To Filer	Rosalind Minor	01/15/2009	01/15/2009
extension	Note To Reviewer	Connie Gates	01/14/2009	01/15/2009
request for extension	Note To Reviewer	Connie Gates	11/25/2008	11/25/2008
Guaranteed Renewablility	Note To Filer	Rosalind Minor	11/17/2008	11/17/2008
Guaranteed Renewable "To Age 75"	Note To Reviewer	Connie Gates	11/11/2008	11/11/2008
Extension of Filing	Note To Filer	Rosalind Minor	11/25/2008	

SERFF Tracking Number:	*AFLA-125856287*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*40777*
Company Tracking Number:	*A72000*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Lump Sum Critical Illness*		
Project Name/Number:	*Lump Sum Critical Illness & Lump Sum Cancer/*		

Disposition

Disposition Date: 02/10/2009
Implementation Date:
Status: Approved-Closed
Comment: This file was reopened to replace Form AsignAR with a revised form. This form is approved effective on this date.

The remainder of the filing will maintain its' orgininal approval date.

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AFLA-125856287*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*40777*
Company Tracking Number:	*A72000*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Lump Sum Critical Illness*		
Project Name/Number:	*Lump Sum Critical Illness & Lump Sum Cancer/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document *(revised)*	Health - Actuarial Justification	Approved-Closed	No
Supporting Document *(revised)*	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Filing Fee Certification	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Replaced	No
Supporting Document	Outline of Coverage	Replaced	Yes
Form *(revised)*	Lump Sum Critical Illness Policy	Approved-Closed	Yes
Form	Lump Sum Critical Illness Policy	Replaced	Yes
Form *(revised)*	Lump Sum Cancer Policy	Approved-Closed	Yes
Form	Lump Sum Cancer Policy	Replaced	Yes
Form	Lump Sum Cancer Benefit Rider	Approved-Closed	Yes
Form	Return of Premium Benefit Rider	Approved-Closed	Yes
Form	Sudden Cardiac Death Benefit Rider	Approved-Closed	Yes
Form *(revised)*	Payroll Application	Approved-Closed	Yes
Form	Payroll Application	Replaced	Yes
Form *(revised)*	Payroll Application	Approved-Closed	Yes
Form	Payroll Application	Replaced	Yes
Form *(revised)*	Union Application	Approved-Closed	Yes
Form	Union Application	Replaced	Yes
Form *(revised)*	Union Application	Approved-Closed	Yes
Form	Union Application	Replaced	Yes
Form *(revised)*	Large Account Application	Approved-Closed	Yes
Form	Large Account Application	Replaced	Yes
Form *(revised)*	Large Account Application	Approved-Closed	Yes
Form	Large Account Application	Replaced	Yes
Form	Underwriting Application	Approved-Closed	Yes
Form	Underwriting Application	Approved-Closed	Yes
Form	Underwriting Application	Approved-Closed	Yes

SERFF Tracking Number:	*AFLA-125856287*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*40777*
Company Tracking Number:	*A72000*		
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Product Name:	*Lump Sum Critical Illness*		
Project Name/Number:	*Lump Sum Critical Illness & Lump Sum Cancer/*		

Form	Underwriting Application	Approved-Closed	Yes
Form	Request for Additions/Application for Reinstatement	Approved-Closed	Yes
Form	Request for Additions/Application for Reinstatement	Approved-Closed	Yes
Form *(revised)*	Signature Form	Approved-Closed	Yes
Form	Signature Form	Replaced	Yes
Form	Signature Form	Approved-Closed	Yes
Form *(revised)*	Outline of Coverage	Approved-Closed	Yes
Form	Outline of Coverage	Approved-Closed	Yes
Form *(revised)*	Outline of Coverage	Approved-Closed	Yes
Form	Outline of Coverage	Replaced	Yes

SERFF Tracking Number:	*AFLA-125856287*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*40777*
Company Tracking Number:	*A72000*		
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Product Name:	*Lump Sum Critical Illness*		
Project Name/Number:	*Lump Sum Critical Illness & Lump Sum Cancer/*		

Disposition

Disposition Date: 02/02/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AFLA-125856287*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*40777*
Company Tracking Number:	*A72000*		
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Product Name:	*Lump Sum Critical Illness*		
Project Name/Number:	*Lump Sum Critical Illness & Lump Sum Cancer/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document *(revised)*	Health - Actuarial Justification	Approved-Closed	No
Supporting Document *(revised)*	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Filing Fee Certification	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Replaced	No
Supporting Document	Outline of Coverage	Replaced	Yes
Form *(revised)*	Lump Sum Critical Illness Policy	Approved-Closed	Yes
Form	Lump Sum Critical Illness Policy	Replaced	Yes
Form *(revised)*	Lump Sum Cancer Policy	Approved-Closed	Yes
Form	Lump Sum Cancer Policy	Replaced	Yes
Form	Lump Sum Cancer Benefit Rider	Approved-Closed	Yes
Form	Return of Premium Benefit Rider	Approved-Closed	Yes
Form	Sudden Cardiac Death Benefit Rider	Approved-Closed	Yes
Form *(revised)*	Payroll Application	Approved-Closed	Yes
Form	Payroll Application	Replaced	Yes
Form *(revised)*	Payroll Application	Approved-Closed	Yes
Form	Payroll Application	Replaced	Yes
Form *(revised)*	Union Application	Approved-Closed	Yes
Form	Union Application	Replaced	Yes
Form *(revised)*	Union Application	Approved-Closed	Yes
Form	Union Application	Replaced	Yes
Form *(revised)*	Large Account Application	Approved-Closed	Yes
Form	Large Account Application	Replaced	Yes
Form *(revised)*	Large Account Application	Approved-Closed	Yes
Form	Large Account Application	Replaced	Yes
Form	Underwriting Application	Approved-Closed	Yes
Form	Underwriting Application	Approved-Closed	Yes
Form	Underwriting Application	Approved-Closed	Yes

SERFF Tracking Number:	*AFLA-125856287*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*40777*
Company Tracking Number:	*A72000*		
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Product Name:	*Lump Sum Critical Illness*		
Project Name/Number:	*Lump Sum Critical Illness & Lump Sum Cancer/*		

Form	Underwriting Application	Approved-Closed	Yes
Form	Request for Additions/Application for Reinstatement	Approved-Closed	Yes
Form	Request for Additions/Application for Reinstatement	Approved-Closed	Yes
Form *(revised)*	Signature Form	Approved-Closed	Yes
Form	Signature Form	Replaced	Yes
Form	Signature Form	Approved-Closed	Yes
Form *(revised)*	Outline of Coverage	Approved-Closed	Yes
Form	Outline of Coverage	Approved-Closed	Yes
Form *(revised)*	Outline of Coverage	Approved-Closed	Yes
Form	Outline of Coverage	Replaced	Yes

SERFF Tracking Number:	*AFLA-125856287*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*40777*
Company Tracking Number:	*A72000*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Lump Sum Critical Illness*		
Project Name/Number:	*Lump Sum Critical Illness & Lump Sum Cancer/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	11/06/2008
Submitted Date	11/06/2008
Respond By Date	

Dear Connie Gates,

This will acknowledge receipt of the captioned filing.

Objection 1

- Health - Actuarial Justification (Supporting Document)

Comment: Please update the actuarial memorandums to change language under the renewablility clause to read Guaranteed Renewable in lieu of Guaranteed Renewable to Age 75.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	01/30/2009
Submitted Date	01/30/2009

Dear Rosalind Minor,

Comments:

Response 1

Comments: The Actuarial Memorandum has been amended in regards to Guaranteed Renewable.

Related Objection 1

Applies To:

- Health - Actuarial Justification (Supporting Document)

Comment:

SERFF Tracking Number:	*AFLA-125856287*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*40777*
Company Tracking Number:	*A72000*		
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Product Name:	*Lump Sum Critical Illness*		
Project Name/Number:	*Lump Sum Critical Illness & Lump Sum Cancer/*		

Please update the actuarial memorandums to change language under the renewablility clause to read Guaranteed Renewable in lieu of Guaranteed Renewable to Age 75.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Health - Actuarial Justification

Comment: The Actuarial Memorandum and Rates are attached below.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,
Connie Gates

SERFF Tracking Number:	*AFLA-125856287*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*40777*
Company Tracking Number:	*A72000*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Lump Sum Critical Illness*		
Project Name/Number:	*Lump Sum Critical Illness & Lump Sum Cancer/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	11/06/2008
Submitted Date	11/06/2008
Respond By Date	

Dear Connie Gates,

This will acknowledge receipt of the captioned filing.

Objection 1

- Lump Sum Critical Illness Policy (Form)

Comment: I am reviewing this policy under Rule 18, Appendix. As outlined under 1A(4), policies containing specified disease coverage shall be at least Guaranteed Renewable.

Objection 2

- Lump Sum Cancer Policy (Form)

Comment: Under Rule 18, Appendix, 1A(4) the policy is to be Guaranteed Renewable. Please remove the wording, "To Age 75.

Objection 3

- Payroll Application (Form)
- Payroll Application (Form)
- Union Application (Form)
- Union Application (Form)
- Large Account Application (Form)
- Large Account Application (Form)

Comment: Please remove the language "To Age 75" with respect to Guaranteed Revewable. See Rule 18, Appendix, 1A(4).

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

Response Letter

SERFF Tracking Number:	*AFLA-125856287*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*40777*
Company Tracking Number:	*A72000*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Lump Sum Critical Illness*		
Project Name/Number:	*Lump Sum Critical Illness & Lump Sum Cancer/*		

Response Letter Status	Submitted to State
Response Letter Date	01/30/2009
Submitted Date	01/30/2009

Dear Rosalind Minor,

Comments:

Response 1

Comments: The requested policy and application forms have been amended in regards to Guaranteed Renewable.

Related Objection 1

Applies To:

- Lump Sum Critical Illness Policy (Form)

Comment:

I am reviewing this policy under Rule 18, Appendix. As outlined under 1A(4), policies containing specified disease coverage shall be at least Guaranteed Renewable.

Related Objection 2

Applies To:

- Lump Sum Cancer Policy (Form)

Comment:

Under Rule 18, Appendix, 1A(4) the policy is to be Guaranteed Renewable. Please remove the wording, "To Age 75.

Related Objection 3

Applies To:

- Payroll Application (Form)
- Payroll Application (Form)
- Union Application (Form)
- Union Application (Form)
- Large Account Application (Form)
- Large Account Application (Form)

Comment:

Please remove the language "To Age 75" with respect to Guaranteed Revewable. See Rule 18, Appendix, 1A(4).

SERFF Tracking Number:	*AFLA-125856287*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*40777*
Company Tracking Number:	*A72000*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Lump Sum Critical Illness*		
Project Name/Number:	*Lump Sum Critical Illness & Lump Sum Cancer/*		

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Lump Sum Critical Illness Policy	A72100AR		Policy/Contract/Fraternal Certificate	Initial		50	A72100AR.pdf
Previous Version							
Lump Sum Critical Illness Policy	*A72100AR*		*Policy/Contract/Fraternal Certificate*	*Initial*		*50*	A72100AR.pdf
Lump Sum Cancer Policy	A72200AR		Policy/Contract/Fraternal Certificate	Initial		51	A72200AR.pdf
Previous Version							
Lump Sum Cancer Policy	*A72200AR*		*Policy/Contract/Fraternal Certificate*	*Initial*		*51*	A72200AR.pdf
Payroll Application	A72PAPPAR		Application/Enrollment Form	Initial		46	A72PAPPAR.pdf
Previous Version							
Payroll Application	*A72PAPPAR*		*Application/Enrollment Form*	*Initial*		*46*	A72PAPPAR.pdf
Payroll Application	A72PCAPPAR		Application/Enrollment Form	Initial		61	A72PCAPPAR.pdf
Previous Version							
Payroll Application	*A72PCAPPAR*		*Application/Enrollment Form*	*Initial*		*61*	A72PCAPPAR.pdf
Union Application	A72UAPPAR		Application/Enrollment Form	Initial		62	A72UAPPAR.pdf
Previous Version							
Union Application	*A72UAPPAR*		*Application/Enrollment Form*	*Initial*		*62*	A72UAPPAR.pdf

SERFF Tracking Number:	*AFLA-125856287*	*State:*	*Arkansas*		
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*40777*		
Company Tracking Number:	*A72000*				
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*		
Product Name:	*Lump Sum Critical Illness*				
Project Name/Number:	*Lump Sum Critical Illness & Lump Sum Cancer/*				

Union Application	A72UCAP PAR	Application/Enrollment Form	Initial	59	A72UCAP PAR.pdf
Previous Version					
Union Application	*A72UCAP PAR*	*Application/Enrollment Form*	*Initial*	*59*	A72UCAP PAR.pdf
Large Account Application	A72GAPP AR	Application/Enrollment Form	Initial	60	A72GAPP AR.pdf
Previous Version					
Large Account Application	*A72GAPP AR*	*Application/Enrollment Form*	*Initial*	*60*	A72GAPP AR.pdf
Large Account Application	A72GCAP PAR	Application/Enrollment Form	Initial	63	A72GCAP PAR.pdf
Previous Version					
Large Account Application	*A72GCAP PAR*	*Application/Enrollment Form*	*Initial*	*63*	A72GCAP PAR.pdf

SERFF Tracking Number:	*AFLA-125856287*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*40777*
Company Tracking Number:	*A72000*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Lump Sum Critical Illness*		
Project Name/Number:	*Lump Sum Critical Illness & Lump Sum Cancer/*		

No Rate/Rule Schedule items changed.

Sincerely,
Connie Gates

SERFF Tracking Number:	*AFLA-125856287*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*40777*
Company Tracking Number:	*A72000*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Lump Sum Critical Illness*		
Project Name/Number:	*Lump Sum Critical Illness & Lump Sum Cancer/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	11/06/2008
Submitted Date	11/06/2008
Respond By Date	

Dear Connie Gates,

This will acknowledge receipt of the captioned filing.

Objection 1

- Outline of Coverage (Form)
- Outline of Coverage (Form)

Comment: Under Rule 18, Appendix 1A(4), this policy should be Guaranteed Renewable not Guaranteed Revewable to Age 75.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	01/30/2009
Submitted Date	01/30/2009

Dear Rosalind Minor,

Comments:

Response 1

Comments: The requested outline of coverage forms have been amended in regards to Guaranteed Renewable.

Related Objection 1

Applies To:

- Outline of Coverage (Form)

SERFF Tracking Number:	*AFLA-125856287*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*40777*
Company Tracking Number:	*A72000*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Lump Sum Critical Illness*		
Project Name/Number:	*Lump Sum Critical Illness & Lump Sum Cancer/*		

- Outline of Coverage (Form)

Comment:
Under Rule 18, Appendix 1A(4), this policy should be Guaranteed Renewable not Guaranteed Revewable to Age 75.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Outline of Coverage
Comment: Outline of Coverage forms attached below.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Outline of Coverage	A72125		Outline of Coverage	Initial		63	A72125AR.pdf
Previous Version							
Outline of Coverage	*A72125*		*Outline of Coverage*	*Initial*		*63*	A72125.pdf
Outline of Coverage	A72225		Outline of Coverage	Initial		70	A72225AR.pdf
Previous Version							
Outline of Coverage	*A72225*		*Outline of Coverage*	*Initial*		*70*	A72225.pdf

No Rate/Rule Schedule items changed.

Sincerely,
Connie Gates

SERFF Tracking Number:	*AFLA-125856287*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*40777*
Company Tracking Number:	*A72000*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Lump Sum Critical Illness*		
Project Name/Number:	*Lump Sum Critical Illness & Lump Sum Cancer/*		

Amendment Letter

Amendment Date:

Submitted Date: 02/10/2009

Comments:

Rosalind,

Form AsignAR does NOT contain the agent's certification statement and will be used in situations where the associate/agent is unable to be present at the time of application. So, the Signature Form AsignAR has been amended by removing the Associate Name/Address and Phone number lines.

Thank you

Connie Gates

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
AsignAR	Application/Enrollment Form	Signature Form	Initial				67	AsignAR.pdf

SERFF Tracking Number:	*AFLA-125856287*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*40777*
Company Tracking Number:	*A72000*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Lump Sum Critical Illness*		
Project Name/Number:	*Lump Sum Critical Illness & Lump Sum Cancer/*		

Note To Filer

Created By:

Rosalind Minor on 01/15/2009 08:45 AM

Last Edited By:

Rosalind Minor

Submitted On:

02/02/2009 01:02 PM

Subject:

Request for Extension

Comments:

As requested in your Note to Reviewer on 1/14/09, this submission is being extended until February 2, 2009.

SERFF Tracking Number:	*AFLA-125856287*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*40777*
Company Tracking Number:	*A72000*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Lump Sum Critical Illness*		
Project Name/Number:	*Lump Sum Critical Illness & Lump Sum Cancer/*		

Note To Reviewer

Created By:
Connie Gates on 01/14/2009 07:45 AM
Last Edited By:
Rosalind Minor
Submitted On:
02/02/2009 01:02 PM
Subject:
extension
Comments:
Rosalind,

Is it possible to ask for an extension February 2, 2009?

Our Actuarial department needs additional time to prepare an updated memo and rates.

SERFF Tracking Number:	*AFLA-125856287*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*40777*
Company Tracking Number:	*A72000*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Lump Sum Critical Illness*		
Project Name/Number:	*Lump Sum Critical Illness & Lump Sum Cancer/*		

Note To Reviewer

Created By:
Connie Gates on 11/25/2008 03:05 PM
Last Edited By:
Rosalind Minor
Submitted On:
02/02/2009 01:02 PM
Subject:
request for extension
Comments:
Rosalind,

Can I have an extension on the resubmission of this filing? Please advise if December 31, 2008, is acceptable?

thank you
Connie Gates

SERFF Tracking Number:	*AFLA-125856287*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*40777*
Company Tracking Number:	*A72000*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Lump Sum Critical Illness*		
Project Name/Number:	*Lump Sum Critical Illness & Lump Sum Cancer/*		

Note To Filer

Created By:

Rosalind Minor on 11/17/2008 02:47 PM

Last Edited By:

Rosalind Minor

Submitted On:

02/02/2009 01:02 PM

Subject:

Guaranteed Renewablility

Comments:

The product which you submitted would be considered a Specified Disease coverage. The guidelines for a specified disease product is under the APPENDIX of Rule 18 and under (4) the policies containing specified disease coverage shall be at least Guaranteed Renewable.

We appreciate your understanding and cooperation.

SERFF Tracking Number:	*AFLA-125856287*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*40777*
Company Tracking Number:	*A72000*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Lump Sum Critical Illness*		
Project Name/Number:	*Lump Sum Critical Illness & Lump Sum Cancer/*		

Note To Reviewer

Created By:
Connie Gates on 11/11/2008 02:26 PM
Last Edited By:
Rosalind Minor
Submitted On:
02/02/2009 01:02 PM
Subject:
Guaranteed Renewable "To Age 75"
Comments:
Rosalind,

You quoted Rule 18, Appendix 1A(4) as the reason to remove "To Age 75". I was reviewing the regulation and recalled the following:

Rule and Regulation 18 s 7 A. (3) "Accident and health minimum standards for benefits"

Wouldn't this allow us to keep "To Age 75" with respect to Guaranteed Renewable?

thank you
Connie

SERFF Tracking Number:	*AFLA-125856287*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*40777*
Company Tracking Number:	*A72000*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Lump Sum Critical Illness*		
Project Name/Number:	*Lump Sum Critical Illness & Lump Sum Cancer/*		

Note To Filer

Created By:

Rosalind Minor on 11/25/2008 03:33 PM

Subject:

Extension of Filing

Comments:

I have extented the time for your response to December 31, 2008, as requested.

SERFF Tracking Number:	*AFLA-125856287*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*40777*
Company Tracking Number:	*A72000*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Lump Sum Critical Illness*		
Project Name/Number:	*Lump Sum Critical Illness & Lump Sum Cancer/*		

Form Schedule

Lead Form Number: A72100AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	A72100AR	Policy/Contract/Fraternal Certificate	Lump Sum Critical Illness Policy	Initial		50	A72100AR.pdf
Approved-Closed	A72200AR	Policy/Contract/Fraternal Certificate	Lump Sum Cancer Policy	Initial		51	A72200AR.pdf
Approved-Closed	A72050	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Lump Sum Cancer Benefit Rider	Initial		79	a72050.pdf
Approved-Closed	A72051	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Return of Premium Benefit Rider	Initial		98	A72051.pdf
Approved-Closed	A72052	Policy/Contract/Fraternal Certificate:	Sudden Cardiac Death Benefit Rider	Initial		96	A72052.pdf

SERFF Tracking Number:	*AFLA-125856287*		*State:*	*Arkansas*		
Filing Company:	*American Family Life Assurance Company of Columbus*		*State Tracking Number:*	*40777*		
Company Tracking Number:	*A72000*					
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*		*Sub-TOI:*	*H07I.001 Critical Illness*		
Product Name:	*Lump Sum Critical Illness*					
Project Name/Number:	*Lump Sum Critical Illness & Lump Sum Cancer/* Amendment, Insert Page, Endorsement or Rider					
Approved-Closed	A72PAPPAR	Application/Enrollment Form	Payroll Application	Initial	46	A72PAPPAR.pdf
Approved-Closed	A72PCAPPAR	Application/Enrollment Form	Payroll Application	Initial	61	A72PCAPPAR.pdf
Approved-Closed	A72UAPPAR	Application/Enrollment Form	Union Application	Initial	62	A72UAPPAR.pdf
Approved-Closed	A72UCAPPAR	Application/Enrollment Form	Union Application	Initial	59	A72UCAPPAR.pdf
Approved-Closed	A72GAPPAR	Application/Enrollment Form	Large Account Application	Initial	60	A72GAPPAR.pdf
Approved-Closed	A72GCAPPAR	Application/Enrollment Form	Large Account Application	Initial	63	A72GCAPPAR.pdf
Approved-Closed	LSCI	Application/Enrollment Form	Underwriting Application	Initial	65	LSCI.pdf
Approved-Closed	LSCIG	Application/Enrollment Form	Underwriting Application	Initial	73	LSCIG.pdf
Approved-Closed	LSCA	Application/Enrollment Form	Underwriting Application	Initial	71	LSCA.pdf
Approved-Closed	LSCAG	Application/Enrollment Form	Underwriting Application	Initial	69	LSCAG.pdf
Approved-	A72003AR	Application/	Request for	Initial	76	A72003AR.pd

SERFF Tracking Number:		*AFLA-125856287*		*State:*		*Arkansas*	
Filing Company:		*American Family Life Assurance Company of Columbus*		*State Tracking Number:*		*40777*	
Company Tracking Number:		*A72000*					
TOI:		*H07I Individual Health - Specified Disease - Limited Benefit*		*Sub-TOI:*		*H07I.001 Critical Illness*	
Product Name:		*Lump Sum Critical Illness*					
Project Name/Number:		*Lump Sum Critical Illness & Lump Sum Cancer/*					
Closed		Enrollment Form	Additions/Application for Reinstatement				f
Approved-Closed	A72003GAR	Application/ Enrollment Form	Request for Additions/Application for Reinstatement	Initial		71	A72003GAR.pdf
Approved-Closed	AsignAR	Application/ Enrollment Form	Signature Form	Initial		67	AsignAR.pdf
Approved-Closed	AsigncAR	Application/ Enrollment Form	Signature Form	Initial		74	AsigncAR.pdf
Approved-Closed	A72125	Outline of Coverage	Outline of Coverage	Initial		63	A72125AR.pdf
Approved-Closed	A72225	Outline of Coverage	Outline of Coverage	Initial		70	A72225AR.pdf

LUMP SUM CRITICAL ILLNESS LIMITED BENEFIT HEALTH INSURANCE COVERAGE

NOTICE TO BUYER: THIS IS A LUMP SUM CRITICAL ILLNESS POLICY. IT PAYS BENEFITS FOR CRITICAL ILLNESSES ONLY. READ IT CAREFULLY WITH THE OUTLINE OF COVERAGE, IF APPLICABLE.

The Named Insured as shown in the Policy Schedule will be referred to as "you," "your," or "yours." **American Family Life Assurance Company of Columbus (Aflac),** a stock company, will be referred to as "we," "our," "us," or "Aflac."

CONSIDERATION

This policy is issued in consideration of statements made in your application and the payment of the premium shown in the Policy Schedule. A copy of your application is attached and is a part of this policy. The following paragraphs set forth the definitions of terms, the limitations and exclusions, the insurance benefits, and other provisions.

YOUR RIGHT TO EXAMINE THIS POLICY

It is important to us that you are satisfied with this policy. If you are not satisfied, you may return it within 30 days after you receive it. Send it to your associate (duly licensed agent) or to Aflac [Worldwide Headquarters, 1932 Wynnton Road, Columbus, Georgia 31999]. You will receive a full refund of all premiums paid, and your policy will be void from its Effective Date. If you return this policy, please note in writing: "This policy is returned for cancellation and refund of premium."

IMPORTANT NOTICE

Please read your application attached to this policy. This policy is issued on the basis that the information shown on the application is correct and complete. Statements made in the application are deemed representations and not warranties. Carefully check the application. Write to us within 30 days of the date you receive this policy if any information on the application is not correct or complete. Incorrect or incomplete information may result in the denial of claims or voiding of the policy. No associate (duly licensed agent) may change this policy or waive any of its provisions.

THIS POLICY IS GUARANTEED-RENEWABLE FOR YOUR LIFETIME, SUBJECT TO AFLAC'S RIGHT TO CHANGE PREMIUMS BY CLASS UPON ANY RENEWAL DATE.

We agree that this policy will never be restricted by the addition of any rider without your consent, nor will renewal be refused because of any change in any Covered Person's health or physical condition. You are guaranteed the right to renew this policy for your lifetime by the timely payment of premiums at the rate in effect at the beginning of each term.

Aflac may change the established premium rate, but only if the rate is changed for all policies of this class. While this policy is in force, no change will be made in your class because of the age, sex, or physical condition of any Covered Person. "Class" means all policies of this form number and premium classification in your state that are then in force. If the established premium rate changes, Aflac will notify you in writing at your last known address, as shown in our records, at least 30 days before the change becomes effective.

PRE-EXISTING CONDITION LIMITATIONS

A Pre-existing Condition is an illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Benefits for a Loss that is caused by a Pre-existing Condition will not be covered unless the Onset Date is more than 12 months after the Effective Date of coverage.

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)
CLIENT SERVICES AND ADMINISTRATION
[WORLDWIDE HEADQUARTERS • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999
FOR ASSISTANCE OR INFORMATION ABOUT THIS POLICY, CALL 1-800-99-AFLAC (1-800-992-3522).
FOR CLAIM FORMS, VISIT OUR WEB SITE AT AFLAC.COM.]
If we at Aflac, fail to provide you with reasonable and adequate service, you should feel free to contact:
ARKANSAS INSURANCE DEPARTMENT - CONSUMER SERVICES DIVISION
1200 WEST THIRD STREET, LITTLE ROCK, ARKANSAS 72201-1904
Telephone (501) 371- 2640 or Toll-Free 1-800-852-5494.

INDEX

Policy Schedule

NAMED INSURED:	John A. Doe	**POLICY NUMBER:**	111-2222
TYPE OF COVERAGE:	Individual	**COVERAGE:**	XXXXXX AAABBB
MODE OF PAYMENT:	Monthly		

PREMIUMS:		**EFFECTIVE DATE:**
Policy:	$xxxxxx	Policy: XX/XX/XXXX
Rider:	$xxxxxx	Rider: XX/XX/XXXX
Rider:	$xxxxxx	Rider: XX/XX/XXXX
Rider:	$xxxxxx	Rider: XX/XX/XXXX

	BENEFIT AMOUNT (per Covered Person):
Policy:	
Major Critical Illness Event Benefit:	$XXXX
Cancer Benefit Rider:	
Internal Cancer Benefit:	$XXXX
Sudden Cardiac Death Benefit Rider:	
Sudden Cardiac Death Benefit:	$XXXX

In witness whereof, Aflac's president and secretary signed this policy in Columbus, Georgia, as of the policy Effective Date shown in the Policy Schedule.

[

Paul S. Amos II, President

Joey M. Loudermilk, Secretary]

This policy is a legal contract between you and Aflac.
READ YOUR POLICY CAREFULLY.

Part 1
DEFINITIONS

A. COMA: a continuous state of profound unconsciousness, diagnosed or treated on or after the Effective Date of coverage, classified on the Glasgow Coma Scale as seven or below and characterized by the absence of (1) spontaneous eye movements, (2) response to painful stimuli, and (3) vocalization. The condition must require intubation for respiratory assistance. The term "Coma" does not include any medically induced coma.

B. CORONARY ARTERY BYPASS GRAFT SURGERY: open-heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, but excluding procedures such as but not limited to coronary angioplasty, valve replacement surgery, stent placement, laser relief, or other surgical or nonsurgical procedures.

C. COVERED PERSON: any person insured under Individual, Named Insured/Spouse Only, One-Parent Family, or Two-Parent Family coverage. See Type of Coverage definition.

D. CRITICAL ILLNESS EVENT: Heart Attack, Stroke, Major Human Organ Transplant, End-Stage Renal Failure, Paralysis, or Coma.

E. DEPENDENT CHILDREN: your natural children, stepchildren, or legally adopted children who are: (1) unmarried; (2) under age 25; and (3) legal dependents for tax exemption purposes under the United States Internal Revenue Service Tax Code. **A Dependent Child must be under age 25 at the time of application to be eligible for coverage.** Coverage of a Dependent Child will terminate on the anniversary date of this policy following the child's 25th birthday. Coverage provided under any One-Parent or Two-Parent Family policy will include any other unmarried Dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became so incapacitated prior to age 25 and while covered under this policy. You must furnish proof of continued incapacity and dependency at Aflac's request, but not more often than annually, after the two-year period following the Dependent Child's 25th birthday.

F. EFFECTIVE DATE: the date(s) coverage begins as shown in the Policy Schedule. The Effective Date of this policy **is not** the date you signed the application for coverage.

G. END-STAGE RENAL FAILURE: permanent and irreversible kidney failure, not of an acute nature, requiring dialysis or a kidney transplant to maintain life.

H. HEART ATTACK: a myocardial infarction, coronary thrombosis, or coronary occlusion. The attack must be positively diagnosed by a Physician and must be evidenced by electrocardiographic findings or clinical findings together with blood enzyme findings. The definition of "Heart Attack" shall not be construed to mean congestive heart failure, atherosclerotic heart disease, angina, coronary artery disease, cardiac arrest, or any other dysfunction of the cardiovascular system. **Sudden Cardiac Arrest is not a Heart Attack.**

I. IMMEDIATE FAMILY: anyone related to you in the following manner: spouse; brothers or sisters (includes stepbrothers and stepsisters); children (includes stepchildren); parents (includes stepparents); grandchildren; father- or mother-in-law; brother- or sister-in-law; and spouses, as applicable, of any of these.

J. INJURY: a bodily injury caused directly by an accident, independent of Sickness, disease, bodily infirmity, or any other cause, occurring on or after the Effective Date of coverage and while coverage is in force.

K. LOSS: a Critical Illness Event or Coronary Artery Bypass Graft Surgery.

L. MAJOR HUMAN ORGAN TRANSPLANT: a surgery that was first recommended by a member of the medical profession after the Effective Date of coverage in which a Covered Person receives, as a result of a surgical transplant, one or more of the following human organs: heart, kidney, liver, lung, or pancreas. **It does not include transplants involving mechanical or nonhuman organs.**

M. ONSET DATE: the date of the occurrence for a Heart Attack or Stroke; the date of diagnosis for End-Stage Renal Failure, Paralysis, or Coma; or the date of surgery for a Major Human Organ Transplant or Coronary Artery Bypass Graft Surgery.

N. PARALYSIS: complete and total loss of use of two or more limbs (paraplegia, quadriplegia, or hemiplegia) for a continuous period of at least 30 days as the result of a spinal cord Injury. The Paralysis must be confirmed by your attending Physician.

O. PHYSICIAN: a person legally qualified to practice medicine, other than you or a member of your Immediate Family, who is licensed as a Physician by the state where treatment is received to treat the type of condition for which a claim is made.

P. SICKNESS: an illness, disease, infection, or any other abnormal physical condition, independent of Injury, occurring on or after the Effective Date of coverage and while coverage is in force.

Q. STROKE: apoplexy due to rupture or acute occlusion of a cerebral artery. The apoplexy must cause complete or partial loss of function involving the motion or sensation of a part of the body and must last more than 24 hours. The Stroke must be positively diagnosed by a Physician based upon documented neurological deficits and confirmatory neuroimaging studies. “Stroke” does not mean head injury, transient ischemic attack (TIA), or cerebrovascular insufficiency.

R. SUDDEN CARDIAC ARREST: sudden, unexpected loss of heart function in which the heart abruptly and without warning stops working as a result of an internal electrical system malfunction of the heart. **Sudden Cardiac Arrest is not a Heart Attack.**

S. TYPE OF COVERAGE: see your Policy Schedule to determine the Type of Coverage issued: Individual, Named Insured/Spouse Only, One-Parent Family, or Two-Parent Family.

1. **Individual:** coverage for only you (the Named Insured listed in the Policy Schedule).

2. **Named Insured/Spouse Only:** coverage for you (the Named Insured) and your spouse. “Your spouse” is defined as the person to whom you are legally married and who is listed on your application.

3. **One-Parent Family:** coverage for you (the Named Insured) and all of your Dependent Children.

4. **Two-Parent Family:** coverage for you (the Named Insured), your spouse, and all of your Dependent Children (or those of your spouse).

Newborn children are automatically covered under the terms of this policy from the moment of birth. Adopted children are covered from the date of the filing of the petition. If this is an Individual or Named Insured/Spouse Only policy, newborn children are automatically covered from the moment of birth, and adopted children are covered from the date of the filing of the petition if the Named Insured applies for coverage within 60 days after the filing of the petition for adoption. However, coverage shall begin from the moment of birth if the petition for adoption and application for coverage are filed within 60 days after the birth of the minor. This coverage shall terminate upon the dismissal or denial of a petition for adoption. Coverage for newborn or adopted children will be in effect through the 90th day following the date of such event. If you desire uninterrupted coverage for a newborn or an adopted child, you must notify Aflac within 90 days of the child's birth or the date the petition for adoption is filed or before the next premium due date, whichever is later. Upon notification, Aflac will convert this policy to One-Parent Family or Two-Parent Family coverage and advise you of the additional premium due. If One-Parent Family or Two-Parent Family coverage is in force, it is not necessary for you to notify Aflac of the birth of your child or the date of the filing of the petition for adoption of a child, and an additional premium payment will not be required. If you desire any other person(s) to be covered after the Effective Date of this policy, you must apply for such coverage, and that person must be added by endorsement. The added person(s) will be subject to the Pre-existing Condition Limitations. If Two-Parent Family coverage is already in force, an additional premium will not be required. Insurance for persons added by endorsement becomes effective on the date specified on the endorsement.

The insurance on any Dependent Child will terminate on the anniversary date of this policy following the Dependent Child's 25th birthday, on the date the child marries, or at the time the child no longer qualifies as a legal dependent for tax exemption purposes under the United States Internal Revenue Service Tax Code, whichever occurs first (for continuation of coverage information, see Part 3, Right of Conversion). Termination will be without prejudice to any claim originating prior to the date of termination. Aflac's acceptance of premium after such date will be considered as premium for only the remaining persons who qualify as Covered Persons under this policy. When coverage on all Dependent Children terminates, you must notify Aflac, in writing, and elect whether to continue this policy on an Individual or Named Insured/Spouse Only basis. After such notice, Aflac will arrange for the payment of the appropriate premium due, including returning any unearned premium. Coverage provided under any One-Parent Family or Two-Parent Family policy will continue to include any other unmarried Dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became so incapacitated prior to age 25 and while covered under this policy. You must furnish proof of continued incapacity and dependency at Aflac's request, but not more often than annually, after the two-year period following the Dependent Child's 25th birthday.

Part 2
LIMITATIONS AND EXCLUSIONS

A. Aflac will not pay benefits for any Loss that is caused by a Pre-existing Condition unless it begins more than 12 months after the Effective Date of coverage. Benefits are payable for only one covered Loss at a time per Covered Person.

B. Aflac will not pay benefits for any event that is diagnosed or treated outside the territorial limits of the United States, its possessions, or the countries of Canada and Mexico.

C. Aflac will not pay benefits whenever coverage provided by this policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

D. For any benefit to be payable, the Onset Date of the Loss must occur on or after the Effective Date of coverage and while coverage is in force. If more than one Loss per Covered Person occurs on the same day, only the highest eligible benefit will be paid.

E. This policy does not cover Loss caused by or resulting from:

1. Using any drug, narcotic, hallucinogen, or chemical substance (unless administered by a Physician and taken according to the Physician's instructions) or voluntarily taking any kind of poison or inhaling any kind of gas or fumes;

2. Participating in, or attempting to participate in, an illegal activity that is defined as a felony, whether charged or not ("felony" is as defined by the law of the jurisdiction in which the activity takes place); or being incarcerated in any type penal institution;

3. Intentionally self-inflicting a bodily injury or committing or attempting suicide, while sane or insane;

4. Being exposed to war or any act of war, declared or undeclared;

5. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve.

Part 3
RIGHT OF CONVERSION

A. DISSOLUTION OF MARRIAGE: If you and your spouse dissolve your marriage by a valid decree of dissolution and your ex-spouse was covered under a Named Insured/Spouse Only or Two-Parent Family policy, your ex-spouse's coverage will terminate. Your ex-spouse may then apply for and receive, without evidence of insurability, a policy providing coverage not greater than the terminated coverage. To obtain the policy, your ex-spouse must make application to Aflac within 60 days following the entry of the decree of dissolution of marriage and pay the appropriate premium for the policy. If such dissolution of marriage occurs, the Named Insured under this policy at the time of the dissolution will retain that status. Any Dependent Children may be covered under either policy, but not both.

B. DEATH: In the event of your death, your spouse, if alive and covered under this policy, will become the Named Insured. All benefits accrued prior to your death will be paid to your estate.

C. TERMINATION OF DEPENDENCY: A Dependent Child whose dependency has terminated and who desires to continue coverage as a Named Insured under a separate policy may do so by notifying Aflac of the request in writing. Such person will have the right to apply for an equivalent policy without evidence of insurability and without interruption in coverage, provided Aflac receives written notification of the request prior to 31 days after the anniversary date of this policy following the date he or she is no longer considered a Dependent Child.

Part 4
UNIFORM PROVISIONS

A. ENTIRE CONTRACT; CHANGES: This policy, together with the application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance. No change in this policy is valid until approved in writing by the president and secretary of Aflac at our worldwide headquarters. Any such change must be noted hereon or attached hereto. No associate (duly licensed agent) has the authority to change this policy or to waive any of its provisions.

B. TIME LIMIT ON CERTAIN DEFENSES: After two years from the Effective Date of this policy, any misstatements, except fraudulent misstatements, made by you in the application will not be used to void this policy or to deny a claim commencing after the expiration of such two-year period. Any claim for Loss commencing after 12 months from the Effective Date of coverage shall not be reduced on the grounds that a physical condition, not excluded from coverage by name or specific description, had existed prior to the Effective Date of coverage. Coverage for Pre-existing Conditions will not be reduced or denied after the policy has been in force 12 months.

C. TERM: You are guaranteed the right to renew this policy for your lifetime by the timely payment of premiums at the rate in effect at the beginning of each term. The term of this policy begins at midnight, standard time, at the place where you reside on the Effective Date shown in the Policy Schedule. It ends at midnight, at the same standard time, on the first renewal date. Each renewal term ends at midnight, at the same standard time, on the next following renewal date. Renewal dates are determined by the mode of payment. The mode of payment for the original term of this policy is shown in the Policy Schedule. An annual premium will maintain this policy in force for 12 months, semiannual for six months, quarterly for three months, and monthly for one month. Premium for a term is due on the first day of that term. **If you fail to pay your premium by the end of the grace period, coverage under this policy will terminate**.

D. GRACE PERIOD: A grace period of 31 days will be granted for the payment of each premium falling due after the first premium. During the grace period, this policy will continue in force.

E. REINSTATEMENT: You may request reinstatement of your policy from your associate (duly licensed agent) or from Aflac. If your policy has lapsed for nonpayment of premium and we accept a later payment without requiring an application, your policy will be reinstated. If we require a written application and provide you with a conditional receipt, your policy will be reinstated upon our approval of the application. If we do not notify you of our disapproval in writing within 45 days of the date your application is received at our worldwide headquarters, your policy will be deemed reinstated. The reinstated policy will cover only Loss with an Onset Date on or after the date of reinstatement. In all other respects, you and Aflac will have the same rights as provided under the policy immediately before the due date of the defaulted premium, subject to any provisions added in connection with the reinstatement. Any premium accepted in connection with a reinstatement will be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

F. NOTICE OF CLAIM: Written notice of claim must be given within 60 days after a covered Loss starts or as soon as reasonably possible. The notice can be given to Aflac at our worldwide headquarters, [1932 Wynnton Rd, Columbus, GA 31999], or to your associate (duly licensed agent). The notice of claim should include the name of the Covered Person and the policy number.

G. CLAIM FORMS: When we receive a notice of claim, we will send you forms for filing proof of loss. If the forms are not given to you within ten working days after the giving of such notice, you will meet the proof-of-loss requirements by giving us a written statement of the nature and extent of the Loss within the time limit stated in the Proof of Loss provision.

H. PROOF OF LOSS: Written proof of loss must be furnished to Aflac at our worldwide headquarters within 90 days after the date of such Loss. Failure to furnish such proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than 15 months from the time proof is otherwise required.

I. TIME OF PAYMENT OF CLAIMS: All benefits payable under this policy will be paid immediately upon receipt of due written proof of loss.

J. PAYMENT OF CLAIMS: All benefits will be payable to you. Any accrued benefits unpaid at your death will be paid to your estate.

K. LEGAL ACTIONS: No legal action may be brought to recover on this policy within 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action may be brought after three years from the time written proof of loss is required to be furnished.

L. PHYSICAL EXAMINATIONS AND AUTOPSY: Aflac, at its own expense, will have the right and opportunity to examine a Covered Person when and as often as it may be reasonably required during the pendency of a claim hereunder, and to make an autopsy in the case of death where autopsy is not forbidden by law.

M. CONFORMITY WITH STATE AND FEDERAL STATUTES: Any provision of this policy that on its Effective Date is in conflict with the statutes of the state in which it was issued or with any federal statute is hereby amended to conform to the minimum requirements of such statutes.

N. OTHER INSURANCE WITH AFLAC: If any person is covered under more than one Aflac policy or rider with Critical Illness, Specified Health Event, or Cancer benefits, only the one chosen by you or your estate, as the case may be, will be effective. Aflac will return all premiums paid for that person for all other Critical Illness, Specified Health Event, or Cancer policies and riders from the date of duplication, less any benefits paid.

O. REFUND OF UNEARNED PREMIUMS: That portion of the premium paid for a period beyond the end of the policy month in which the Named Insured died shall be paid in a lump sum on a date no later than 30 days after the proof of the Named Insured's death has been furnished to Aflac. Exception: Where Named Insured/Spouse, One-Parent Family or Two-Parent Family coverage is continued, no refund is applicable.

Should the Named Insured cancel this policy prior to its renewal date, Aflac will refund to the Named Insured the unearned portion of such premiums paid for any period beyond the end of the policy month in which the cancellation occurred.

Part 5
BENEFITS

While this coverage is in force, we will pay the following benefits, as applicable, subject to the Pre-existing Condition Limitations, Limitations and Exclusions, and all other policy provisions.

For any benefit to be payable, the Onset Date of the Loss must occur on or after the Effective Date of coverage and while coverage is in force. If more than one Loss per Covered Person occurs on the same day, only the highest eligible benefit will be paid. Aflac will not accept an assignment of these benefits. All benefits will be payable to you. Any accrued benefits unpaid at your death will be paid to your estate.

A. MAJOR CRITICAL ILLNESS EVENT BENEFIT: Aflac will pay [$ _____] upon a Covered Person's Onset Date of any of the following Critical Illness Events:

1) Heart Attack
2) Stroke
3) End-Stage Renal Failure
4) Coma
5) Paralysis
6) Major Human Organ Transplant

After qualifying for this benefit, such Covered Person will again become eligible for this benefit after five years from the later of (1) the Onset Date of any Critical Illness Event of such Covered Person or (2) the latest hospitalization or surgery due to such Covered Person's Critical Illness Event. No lifetime maximum.

B. SUBSEQUENT CRITICAL ILLNESS EVENT BENEFIT: After a Covered Person has previously qualified for benefits under Benefit A above, Aflac will pay $5,000 upon that Covered Person's Onset Date of:

1) a **recurrence** of that **same** Critical Illness Event or
2) an occurrence of a **different** Critical Illness Event.

For this benefit to be payable, the Onset Date of the Critical Illness Event must be 180 days or more from the Onset Date of any previously paid Critical Illness Event for such Covered Person. This benefit is not payable on the same day as the Major Critical Illness Event Benefit. No lifetime maximum.

C. CORONARY ARTERY BYPASS GRAFT SURGERY BENEFIT: Aflac will pay $3,000 when a Covered Person undergoes Coronary Artery Bypass Graft Surgery. This benefit is payable once per Covered Person, per lifetime.

LUMP SUM CANCER LIMITED BENEFIT HEALTH INSURANCE COVERAGE

NOTICE TO BUYER: THIS IS A LUMP SUM CANCER POLICY. IT PAYS BENEFITS FOR CANCER ONLY. READ IT CAREFULLY WITH THE OUTLINE OF COVERAGE, IF APPLICABLE.

The Named Insured as shown in the Policy Schedule will be referred to as "you," "your," or "yours." **American Family Life Assurance Company of Columbus (Aflac),** a stock company, will be referred to as "we," "our," "us," or "Aflac."

CONSIDERATION

This policy is issued in consideration of statements made in your application and the payment of the premium shown in the Policy Schedule. A copy of your application is attached and is a part of this policy. The following paragraphs set forth the definitions of terms, the limitations and exclusions, the insurance benefits, and other provisions.

YOUR RIGHT TO EXAMINE THIS POLICY

It is important to us that you are satisfied with this policy. If you are not satisfied, you may return it within 30 days after you receive it. Send it to your associate (duly licensed agent) or to Aflac [Worldwide Headquarters, 1932 Wynnton Road, Columbus, Georgia 31999]. You will receive a full refund of all premiums paid, and your policy will be void from its Effective Date. If you return this policy, please note in writing: "This policy is returned for cancellation and refund of premium."

IMPORTANT NOTICE

Please read your application attached to this policy. This policy is issued on the basis that the information shown on the application is correct and complete. Statements made in the application are deemed representations and not warranties. Carefully check the application. Write to us within 30 days of the date you receive this policy if any information on the application is not correct or complete. Incorrect or incomplete information may result in the denial of claims or voiding of the policy. No associate (duly licensed agent) may change this policy or waive any of its provisions.

THIS POLICY IS GUARANTEED-RENEWABLE FOR YOUR LIFETIME, SUBJECT TO AFLAC'S RIGHT TO CHANGE PREMIUMS BY CLASS UPON ANY RENEWAL DATE.

We agree that this policy will never be restricted by the addition of any rider without your consent, nor will renewal be refused because of any change in any Covered Person's health or physical condition. You are guaranteed the right to renew this policy for your lifetime by the timely payment of premiums at the rate in effect at the beginning of each term.

Aflac may change the established premium rate, but only if the rate is changed for all policies of this class. While this policy is in force, no change will be made in your class because of the age, sex, or physical condition of any Covered Person. "Class" means all policies of this form number and premium classification in your state that are then in force. If the established premium rate changes, Aflac will notify you in writing at your last known address, as shown in our records, at least 30 days before the change becomes effective.

PRE-EXISTING CONDITION LIMITATIONS

A Pre-existing Condition is an illness, disease, infection, or disorder for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Benefits for a Loss that is caused by a Pre-existing Condition will not be covered unless the Onset Date is more than 12 months after the Effective Date of coverage.

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)
CLIENT SERVICES AND ADMINISTRATION
[WORLDWIDE HEADQUARTERS • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999
FOR ASSISTANCE OR INFORMATION ABOUT THIS POLICY, CALL 1-800-99-AFLAC (1-800-992-3522).
FOR CLAIM FORMS, VISIT OUR WEB SITE AT AFLAC.COM.]
If we at Aflac, fail to provide you with reasonable and adequate service, you should feel free to contact:
ARKANSAS INSURANCE DEPARTMENT - CONSUMER SERVICES DIVISION
1200 WEST THIRD STREET, LITTLE ROCK, ARKANSAS 72201-1904
Telephone (501) 371- 2640 or Toll-Free 1-800-852-5494.

INDEX

Policy Schedule

NAMED INSURED:	John A. Doe	**POLICY NUMBER:**	111-2222
TYPE OF COVERAGE:	Individual	**COVERAGE:**	XXXXXX AAABBB
MODE OF PAYMENT:	Monthly		

PREMIUMS:
Policy: $xxxxxx
Rider: $xxxxxx

EFFECTIVE DATE:
Policy: XX/XX/XXXX
Rider: XX/XX/XXXX

BENEFIT AMOUNT (per Covered Person):
Internal Cancer Benefit Amount: $XXXX

In witness whereof, Aflac's president and secretary signed this policy in Columbus, Georgia, as of the policy Effective Date shown in the Policy Schedule.

[

Paul S. Amos II, President

Joey M. Loudermilk, Secretary]

This policy is a legal contract between you and Aflac.
READ YOUR POLICY CAREFULLY.

Part 1
DEFINITIONS

A. CANCER-RELATED DEATH: death as a result of Internal Cancer. Internal Cancer must be listed as the primary or a contributing cause of death on the death certificate.

B. CARCINOMA IN SITU: a carcinoma in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

C. COVERED PERSON: any person insured under Individual, Named Insured/Spouse Only, One-Parent Family, or Two-Parent Family coverage. See Type of Coverage definition.

D. DEPENDENT CHILDREN: your natural children, stepchildren, or legally adopted children who are: (1) unmarried; (2) under age 25; and (3) legal dependents for tax exemption purposes under the United States Internal Revenue Service Tax Code. **A Dependent Child must be under age 25 at the time of application to be eligible for coverage.** Coverage of a Dependent Child will terminate on the anniversary date of this policy following the child's 25th birthday. Coverage provided under any One-Parent or Two-Parent Family policy will include any other unmarried Dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became so incapacitated prior to age 25 and while covered under this policy. You must furnish proof of continued incapacity and dependency at Aflac's request, but not more often than annually, after the two-year period following the Dependent Child's 25th birthday.

E. EFFECTIVE DATE: the date(s) coverage begins as shown in the Policy Schedule. The Effective Date of this policy **is not** the date you signed the application for coverage.

F. IMMEDIATE FAMILY: anyone related to you in the following manner: spouse; brothers or sisters (includes stepbrothers and stepsisters); children (includes stepchildren); parents (includes stepparents); grandchildren; father- or mother-in-law; brother- or sister-in-law; and spouses, as applicable, of any of these.

G. INTERNAL CANCER: disease manifested by the presence of a malignant tumor and characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Internal Cancer also includes but is not limited to leukemia, Hodgkin's disease, myeloproliferative and myelodysplastic blood disorders, and invasive melanoma of Clark's Level III or higher, or a Breslow level greater than 1.5 mm. Internal Cancer must receive a Positive Medical Diagnosis. Premalignant conditions or conditions with malignant potential, other than those specifically named above, are not considered Internal Cancer. Internal Cancer does not include Nonmelanoma Skin Cancers, Noninvasive Melanoma Skin Cancers, or Carcinoma In Situ.

H. LOSS: Internal Cancer, Carcinoma In Situ, or Cancer-Related Death.

I. ONSET DATE: the day the tissue specimen, culture, and/or titer is taken upon which the diagnosis of Internal Cancer or Carcinoma In Situ is based. The Onset Date is not the date the diagnosis is communicated to the Covered Person.

J. PHYSICIAN: a person legally qualified to practice medicine, other than you or a member of your Immediate Family, who is licensed as a Physician by the state where treatment is received to treat the type of condition for which a claim is made.

K. POSITIVE MEDICAL DIAGNOSIS: a diagnosis of an Internal Cancer by a Physician who is certified by the American Board of Pathology to practice pathologic anatomy or by a certified osteopathic pathologist. Pathologic interpretation of the histology of skin lesions will be accepted from dermatologists certified by the American Board of Dermatopathology. The diagnosis must be based on a microscopic examination of fixed tissue or preparations from the hemic system (either during life or postmortem). The pathologist making the diagnosis will base judgment solely on the criteria of "malignancy" as accepted by the American Board of Pathology or the Osteopathic Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue, or specimen. A clinical diagnosis of Internal Cancer will be accepted as evidence that Internal Cancer exists when a pathological diagnosis cannot be made, provided medical evidence substantially documents the diagnosis of Internal Cancer. Such pathological report or, if applicable, clinical diagnosis must be submitted to Aflac for benefits to be payable.

L. SKIN CANCER: a cancer that forms in the tissues of the skin and is confined to the skin. There are several types of Skin Cancer. Skin Cancer that forms in melanocytes (skin cells that make pigment) is called melanoma.

1. **NONMELANOMA SKIN CANCER:** a cancer other than a melanoma that begins in the upper part of the skin (epidermis).

2. **NONINVASIVE MELANOMA SKIN CANCER:** a cancer that has not spread outside the tissue in which it began and includes melanoma of Clark's Level I or II, or a Breslow Level less than or equal to 1.5 mm.

M. TYPE OF COVERAGE: see your Policy Schedule to determine the Type of Coverage issued: Individual, Named Insured/Spouse Only, One-Parent Family, or Two-Parent Family.

1. **Individual:** coverage for only you (the Named Insured listed in the Policy Schedule).

2. **Named Insured/Spouse Only:** coverage for you (the Named Insured) and your spouse. "Your spouse" is defined as the person to whom you are legally married and who is listed on your application.

3. **One-Parent Family:** coverage for you (the Named Insured) and all of your Dependent Children.

4. **Two-Parent Family:** coverage for you (the Named Insured), your spouse, and all of your Dependent Children (or those of your spouse).

Newborn children are automatically covered under the terms of this policy from the moment of birth. Adopted children are covered from the date of the filing of the petition. If this is an Individual or Named Insured/Spouse Only policy, newborn children are automatically covered from the moment of birth, and adopted children are covered from the date of the filing of the petition if the Named Insured applies for coverage within 60 days after the filing of the petition for adoption. However, coverage shall begin from the moment of birth if the petition for adoption and application for coverage are filed within 60 days after the birth of the minor. This coverage shall terminate upon the dismissal or denial of a petition for adoption. Coverage for newborn or adopted children will be in effect through the 90th day following the date of such event. If you desire uninterrupted coverage for a newborn or an adopted child, you must

notify Aflac within 90 days of the child's birth or the date the petition for adoption is filed or before the next premium due date, whichever is later. Upon notification, Aflac will convert this policy to One-Parent Family or Two-Parent Family coverage and advise you of the additional premium due. If One-Parent Family or Two-Parent Family coverage is in force, it is not necessary for you to notify Aflac of the birth of your child or the date of the filing of the petition for adoption of a child, and an additional premium payment will not be required. If you desire any other person(s) to be covered after the Effective Date of this policy, you must apply for such coverage, and that person must be added by endorsement. The added person(s) will be subject to the Pre-existing Condition Limitations. If Two-Parent Family coverage is already in force, an additional premium will not be required. Insurance for persons added by endorsement becomes effective on the date specified on the endorsement.

The insurance on any Dependent Child will terminate on the anniversary date of this policy following the Dependent Child's 25th birthday, on the date the child marries, or at the time the child no longer qualifies as a legal dependent for tax exemption purposes under the United States Internal Revenue Service Tax Code, whichever occurs first (for continuation of coverage information, see Part 3, Right of Conversion). Termination will be without prejudice to any claim originating prior to the date of termination. Aflac's acceptance of premium after such date will be considered as premium for only the remaining persons who qualify as Covered Persons under this policy. When coverage on all Dependent Children terminates, you must notify Aflac, in writing, and elect whether to continue this policy on an Individual or Named Insured/Spouse Only basis. After such notice, Aflac will arrange for the payment of the appropriate premium due, including returning any unearned premium. Coverage provided under any One-Parent Family or Two-Parent Family policy will continue to include any other unmarried Dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became so incapacitated prior to age 25 and while covered under this policy. You must furnish proof of continued incapacity and dependency at Aflac's request, but not more often than annually, after the two-year period following the Dependent Child's 25th birthday.

Part 2
LIMITATIONS AND EXCLUSIONS

A. Benefits are not provided for premalignant conditions or conditions with malignant potential (unless specifically covered); complications of cancer; or any other disease, sickness, or incapacity. Aflac will not pay benefits for recurrence, direct extension, or metastatic spread of any cancer diagnosed prior to the Effective Date of coverage.

B. Aflac will not pay benefits for any Loss that is caused by a Pre-existing Condition unless the Onset Date is more than 12 months after the Effective Date of coverage. Benefits are payable for only one covered Loss at a time per Covered Person.

C. Aflac will not pay benefits for a Loss that is diagnosed outside the territorial limits of the United States, its possessions, or the countries of Canada and Mexico.

D. Aflac will not pay benefits whenever coverage provided by this policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

E. For benefits to be payable, the Onset Date must occur on or after the Effective Date of coverage, while coverage is in force, and must be separated by 180 days or more from the Onset Date of any other covered Loss for such Covered Person. If more than one Loss per Covered Person occurs within 180 days, only the highest eligible benefit will be paid.

F. Aflac will not pay benefits for Skin Cancers.

Part 3
RIGHT OF CONVERSION

A. DISSOLUTION OF MARRIAGE: If you and your spouse dissolve your marriage by a valid decree of dissolution and your ex-spouse was covered under a Named Insured/Spouse Only or Two-Parent Family policy, your ex-spouse's coverage will terminate. Your ex-spouse may then apply for and receive, without evidence of insurability, a policy providing coverage not greater than the terminated coverage. To obtain the policy, your ex-spouse must make application to Aflac within 60 days following the entry of the decree of dissolution of marriage and pay the appropriate premium for the policy. If such dissolution of marriage occurs, the Named Insured under this policy at the time of the dissolution will retain that status. Any Dependent Children may be covered under either policy, but not both.

B. DEATH: In the event of your death, your spouse, if alive and covered under this policy, will become the Named Insured. All benefits accrued prior to your death will be paid to your estate.

C. TERMINATION OF DEPENDENCY: A Dependent Child whose dependency has terminated and who desires to continue coverage as a Named Insured under a separate policy may do so by notifying Aflac of the request in writing. Such person will have the right to apply for an equivalent policy without evidence of insurability and without interruption in coverage, provided Aflac receives written notification of the request prior to 31 days after the anniversary date of this policy following the date he or she is no longer considered a Dependent Child.

Part 4
UNIFORM PROVISIONS

A. ENTIRE CONTRACT; CHANGES: This policy, together with the application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance. No change in this policy is valid until approved in writing by the president and secretary of Aflac at our worldwide headquarters. Any such change must be noted hereon or attached hereto. No associate (duly licensed agent) has the authority to change this policy or to waive any of its provisions.

B. TIME LIMIT ON CERTAIN DEFENSES: After two years from the Effective Date of this policy, any misstatements, except fraudulent misstatements, made by you in the application will not be used to void this policy or to deny a claim commencing after the expiration of such two-year period. Any claim for Loss commencing after 12 months from the Effective Date of coverage shall not be reduced on the grounds that a physical condition, not excluded from coverage by name or specific description, had existed prior to the Effective Date of coverage. Coverage for Pre-existing Conditions will not be reduced or denied after the policy has been in force 12 months.

C. TERM: You are guaranteed the right to renew this policy for your lifetime by the timely payment of premiums at the rate in effect at the beginning of each term. The term of this policy begins at midnight, standard time, at the place where you reside on the Effective Date shown in the Policy Schedule. It ends at midnight, at the same standard time, on the first renewal date. Each renewal term ends at midnight, at the same standard time, on the next following renewal date. Renewal dates are determined by the mode of payment. The mode of payment for the original term of this policy is shown in the Policy Schedule. An annual premium will maintain this policy in force for 12 months, semiannual for six months, quarterly for three months, and monthly for one month. Premium for a term is due on the first day of that

term. **If you fail to pay your premium by the end of the grace period, coverage under this policy will terminate**.

D. GRACE PERIOD: A grace period of 31 days will be granted for the payment of each premium falling due after the first premium. During the grace period, this policy will continue in force.

E. REINSTATEMENT: You may request reinstatement of your policy from your associate (duly licensed agent) or from Aflac. If your policy has lapsed for nonpayment of premium and we accept a later payment without requiring an application, your policy will be reinstated. If we require a written application and provide you with a conditional receipt, your policy will be reinstated upon our approval of the application. If we do not notify you of our disapproval in writing within 45 days of the date your application is received at our worldwide headquarters, your policy will be deemed reinstated. The reinstated policy will cover only Loss with an Onset Date on or after the date of reinstatement. In all other respects, you and Aflac will have the same rights as provided under the policy immediately before the due date of the defaulted premium, subject to any provisions added in connection with the reinstatement. Any premium accepted in connection with a reinstatement will be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

F. NOTICE OF CLAIM: Written notice of claim must be given within 60 days after a covered Loss starts or as soon as reasonably possible. The notice can be given to Aflac at our worldwide headquarters, [1932 Wynnton Rd, Columbus, GA 31999], or to your associate (duly licensed agent). The notice of claim should include the name of the Covered Person and the policy number.

G. CLAIM FORMS: When we receive a notice of claim, we will send you forms for filing proof of loss. If the forms are not given to you within ten working days after the giving of such notice, you will meet the proof-of-loss requirements by giving us a written statement of the nature and extent of the Loss within the time limit stated in the Proof of Loss provision.

H. PROOF OF LOSS: Written proof of loss must be furnished to Aflac at our worldwide headquarters within 90 days after the date of such Loss. Failure to furnish such proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than 15 months from the time proof is otherwise required.

I. TIME OF PAYMENT OF CLAIMS: All benefits payable under this policy will be paid immediately upon receipt of due written proof of loss.

J. PAYMENT OF CLAIMS: All benefits will be payable to you. Any accrued benefits unpaid at your death will be paid to your estate.

K. LEGAL ACTIONS: No legal action may be brought to recover on this policy within 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action may be brought after three years from the time written proof of loss is required to be furnished.

L. PHYSICAL EXAMINATIONS AND AUTOPSY: Aflac, at its own expense, will have the right and opportunity to examine a Covered Person when and as often as it may be reasonably

required during the pendency of a claim hereunder, and to make an autopsy in the case of death where autopsy is not forbidden by law.

M. CONFORMITY WITH STATE AND FEDERAL STATUTES: Any provision of this policy that on its Effective Date is in conflict with the statutes of the state in which it was issued or with any federal statute is hereby amended to conform to the minimum requirements of such statutes.

N. OTHER INSURANCE WITH AFLAC: If any person is covered under more than one Aflac Cancer policy or Cancer rider, only the one chosen by you or your estate, as the case may be, will be effective. Aflac will return all premiums paid for that person for all other Cancer policies or Cancer riders from the date of duplication, less any benefits paid.

O. REFUND OF UNEARNED PREMIUMS: That portion of the premium paid for a period beyond the end of the policy month in which the Named Insured died shall be paid in a lump sum on a date no later than 30 days after the proof of the Named Insured's death has been furnished to Aflac. Exception: Where Named Insured/Spouse, One-Parent Family or Two-Parent Family coverage is continued, no refund is applicable.

Should the Named Insured cancel this policy prior to its renewal date, Aflac will refund to the Named Insured the unearned portion of such premiums paid for any period beyond the end of the policy month in which the cancellation occurred.

Part 5
BENEFITS

While this coverage is in force, we will pay the following benefits, as applicable, subject to the Pre-existing Condition Limitations, Limitations and Exclusions, and all other policy provisions.

For benefits to be payable, the Onset Date of the Loss must occur on or after the Effective Date of coverage, while coverage is in force, and must be separated by 180 days or more from the Onset Date of any other covered Loss for such Covered Person. If more than one Loss per Covered Person occurs within 180 days, only the highest eligible benefit will be paid. Aflac will not accept an assignment of these benefits. All benefits will be payable to you. Any accrued benefits unpaid at your death will be paid to your estate.

A. INTERNAL CANCER BENEFIT: Aflac will pay [$ _____] upon a Covered Person's Onset Date of Internal Cancer. This benefit is payable once per Covered Person, per lifetime.

B. CARCINOMA IN SITU BENEFIT: Aflac will pay $2,000 upon a Covered Person's Onset Date of Carcinoma In Situ. This benefit is payable once per Covered Person, per lifetime.

C. CANCER-RELATED DEATH BENEFIT: Aflac will pay $5,000 when a Covered Person suffers a Cancer-Related Death.

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)
[Worldwide Headquarters • Columbus, Georgia 31999]
A Stock Company

This **LUMP SUM CANCER BENEFIT RIDER** is a part of the policy and is subject to all policy provisions unless modified herein.

Part 1
EFFECTIVE DATE

The Effective Date of this rider is as stated in the Policy Schedule.

Part 2
DEFINITIONS

A. CANCER-RELATED DEATH: death as a result of Internal Cancer. Internal Cancer must be listed as the primary or a contributing cause of death on the death certificate

B. CARCINOMA IN SITU: a carcinoma in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

C. INTERNAL CANCER: disease manifested by the presence of a malignant tumor and characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Internal Cancer also includes but is not limited to leukemia, Hodgkin's disease, myeloproliferative and myelodysplastic blood disorders, and invasive melanoma of Clark's Level III or higher, or a Breslow level greater than 1.5 mm. Internal Cancer must receive a Positive Medical Diagnosis. Premalignant conditions or conditions with malignant potential, other than those specifically named above, are not considered Internal Cancer. Internal Cancer does not include Nonmelanoma Skin Cancers, Noninvasive Melanoma Skin Cancers, or Carcinoma In Situ.

D. LOSS: Internal Cancer, Carcinoma In Situ, or Cancer-Related Death.

E. ONSET DATE: the day the tissue specimen, culture, and/or titer is taken upon which the diagnosis of Internal Cancer or Carcinoma In Situ is based. The Onset Date is not the date the diagnosis is communicated to the Covered Person.

F. POSITIVE MEDICAL DIAGNOSIS: a diagnosis of an Internal Cancer by a Physician who is certified by the American Board of Pathology to practice pathologic anatomy or by a certified osteopathic pathologist. Pathologic interpretation of the histology of skin lesions will be accepted from dermatologists certified by the American Board of Dermatopathology. The diagnosis must be based on a microscopic examination of fixed tissue or preparations from the hemic system (either during life or postmortem). The pathologist making the diagnosis will base judgment solely on the criteria of "malignancy" as accepted by the American Board of Pathology or the Osteopathic Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue, or specimen. A clinical diagnosis of Internal Cancer will be accepted as evidence that Internal Cancer exists when a pathological diagnosis cannot be made, provided medical evidence substantially documents the diagnosis of Internal Cancer. Such pathological report or, if applicable, clinical diagnosis must be submitted to Aflac for benefits to be payable.

G. SKIN CANCER: a cancer that forms in the tissues of the skin and is confined to the skin. There are several types of Skin Cancer. Skin Cancer that forms in melanocytes (skin cells that make pigment) is called melanoma.

1. **NONMELANOMA SKIN CANCER:** a cancer other than a melanoma that begins in the upper part of the skin (epidermis).

2. **NONINVASIVE MELANOMA SKIN CANCER:** a cancer that has not spread outside the tissue in which it began and includes melanoma of Clark's Level I or II, or a Breslow Level less than or equal to 1.5 mm.

Part 3
LIMITATIONS AND EXCLUSIONS

A. Benefits are not provided for premalignant conditions or conditions with malignant potential (unless specifically covered); complications of cancer; or any other disease, sickness, or incapacity. Aflac will not pay benefits for recurrence, direct extension, or metastatic spread of any cancer diagnosed prior to the Effective Date of coverage.

B. Aflac will not pay benefits for any Loss that is caused by a Pre-existing Condition unless the Onset Date is more than 12 months after the Effective Date of coverage. Benefits are payable for only one covered Loss at a time per Covered Person.

C. Aflac will not pay benefits for a Loss that is diagnosed outside the territorial limits of the United States, its possessions, or the countries of Canada and Mexico.

D. Aflac will not pay benefits whenever coverage provided by this rider is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

E. For benefits to be payable, the Onset Date must occur on or after the Effective Date of coverage, while coverage is in force, and must be separated by 180 days or more from the Onset Date of any other covered Loss. If more than one Loss per Covered Person occurs within 180 days, only the highest eligible benefit will be paid.

F. Aflac will not pay benefits for Skin Cancers.

Part 4
BENEFITS

While this coverage is in force, we will pay the following benefits, as applicable, subject to the Pre-existing Condition Limitations, Limitations and Exclusions, and all other policy provisions unless modified herein.

For benefits to be payable, the Onset Date of the Loss must occur on or after the Effective Date of coverage, while coverage is in force, and must be separated by 180 days or more from the Onset Date of any other covered Loss. If more than one Loss per Covered Person occurs within 180 days, only the highest eligible benefit will be paid. Aflac will not accept an assignment of these benefits. All benefits will be payable to you. Any accrued benefits unpaid at your death will be paid to your estate.

A. INTERNAL CANCER BENEFIT: Aflac will pay [$ _____] upon a Covered Person's Onset Date of Internal Cancer. This benefit is payable once per Covered Person, per lifetime.

B. CARCINOMA IN SITU BENEFIT: Aflac will pay $2,000 upon a Covered Person's Onset Date of Carcinoma In Situ. This benefit is payable once per Covered Person, per lifetime.

C. CANCER-RELATED DEATH BENEFIT: Aflac will pay $5,000 when a Covered Person suffers a Cancer-Related Death.

Part 5
TERMINATION

This rider will terminate upon the earlier of the termination of the policy to which it is attached, the failure to pay the premiums for this rider, or the date upon which there are no longer any payable benefits for any Covered Person.

In witness whereof, Aflac's president and secretary signed this rider in Columbus, Georgia, as of the rider Effective Date shown in the Policy Schedule.

[
Paul S. Amos II, President Joey M. Loudermilk, Secretary]

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)
[Worldwide Headquarters • Columbus, Georgia 31999]
A Stock Company

This **RETURN OF PREMIUM BENEFIT RIDER** is a part of the policy and is subject to all policy provisions unless modified herein.

Part 1
EFFECTIVE DATE

The Effective Date of this rider is the Effective Date listed on the Policy Schedule.

Part 2
BENEFITS

RETURN OF PREMIUM BENEFIT: Aflac will pay you a cash value based upon the annualized premium paid for this rider, the policy, and any other attached benefit riders **(premium paid for the policy and other attached benefit riders will be calculated at the original premium in effect on the rider Effective Date and will not include premium increases that may occur for the policy or other such riders)**. All Return of Premium Benefits/cash values paid will be less any claims paid. If you surrender this rider for its cash value after the Onset Date of a Loss but before claims are submitted, we will reduce subsequent claim payment(s) by the amount of the cash value paid. Both the policy and the rider must remain in force for 20 consecutive years for you to obtain a maximum refund of premiums paid.

The cash value for premium paid for the policy and rider begins on the fifth rider anniversary date.

Your cash value is based upon annualized premium of **xxxxxxx**. If you surrender this rider after its fifth anniversary and such surrender occurs between rider anniversaries, a prorated amount for the partial year will be paid. The proration will be calculated by taking the cash value difference between the last and next anniversary dates, dividing by 12, and multiplying by the number of months that premiums were earned in the partial year at the time of surrender. This proration will then be added to the cash value on the last rider anniversary date, and this will be the cash value paid.

CASH VALUE TABLE

Rider Anniversary Year Ending	% of Premium Return (less any claims paid)	Cash Value Amount (less any claims paid)
5	12%	
6	17%	
7	22%	
8	27%	
9	32%	
10	37%	
11	42%	
12	48%	
13	54%	

Rider Anniversary Year Ending	% of Premium Return (less any claims paid)	Cash Value Amount (less any claims paid)
14	60%	
15	66%	
16	72%	
17	79%	
18	86%	
19	93%	
20	100%	

IMPORTANT! READ CAREFULLY: This rider will terminate on the earlier of: its 20th anniversary date and payment of the cash value; your surrender of it for its cash value between the fifth and 20th anniversary dates; your death prior to its 20th anniversary date, in which case the cash value (if any) will be paid to your estate; your failure to pay the premium for this rider, in which case any cash values due will be paid; the policy's termination, in which case any cash values due will be paid; or the time that claims paid equal or exceed the cash value that would be paid on the 20th policy anniversary. When this rider terminates (is no longer in force), no further premium will be charged for it.

Part 3
TERMINATION

This rider will terminate if the policy to which it is attached terminates or if the premium for this rider is not paid.

In witness whereof, Aflac's president and secretary signed this rider in Columbus, Georgia, as of the Effective Date shown in the Policy Schedule.

[Paul S. Amos II, President

Joey M. Loudermilk, Secretary]

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)
[Worldwide Headquarters • Columbus, Georgia 31999]
A Stock Company

This **SUDDEN CARDIAC DEATH BENEFIT RIDER** is a part of the policy and is subject to all policy provisions unless modified herein.

Part 1
EFFECTIVE DATE

The Effective Date of this rider is as stated in the Policy Schedule.

Part 2
DEFINITIONS

A. LOSS: Sudden Cardiac Death.

B. ONSET DATE: the date of death for Sudden Cardiac Death.

C. SUDDEN CARDIAC DEATH: Death without resuscitation as the result of Sudden Cardiac Arrest. The primary cause of death as shown on the death certificate must be sudden cardiac arrest, cardiac arrest, or sudden cardiac death. **Sudden Cardiac Arrest is not a Heart Attack.**

Part 3
BENEFITS

While this coverage is in force, we will pay the following benefit, as applicable, subject to the Pre-existing Condition Limitations, Limitations and Exclusions, and all other policy provisions unless modified herein.

For benefits to be payable, the Onset Date must occur on or after the Effective Date of coverage, while coverage is in force, and must be separated by 180 days or more from the Onset Date of any previously paid Critical Illness Event for such Covered Person. If Sudden Cardiac Death occurs within 180 days of a Critical Illness Event for the same Covered Person, only the highest eligible benefit will be paid. If Coronary Artery Bypass Graft Surgery and Sudden Cardiac Death occur on the same day, only the highest eligible benefit will be paid. Aflac will not accept an assignment of these benefits. All benefits will be payable to you or your estate.

A. SUDDEN CARDIAC DEATH BENEFIT: Aflac will pay [$_____] upon a Covered Person's Onset Date of Sudden Cardiac Death. This benefit is payable once per Covered Person, per lifetime.

Part 4
TERMINATION

This rider will terminate upon the earlier of the termination of the policy to which it is attached, the failure to pay the premiums for this rider, or the date upon which there are no longer any payable benefits for any Covered Person.

In witness whereof, Aflac's president and secretary signed this rider in Columbus, Georgia, as of the rider Effective Date shown in the Policy Schedule.

[
Paul S. Amos II, President

Joey M. Loudermilk, Secretary]

Payroll

LUMP SUM CRITICAL ILLNESS INSURANCE POLICY (A72100 Series)
Supplemental Health Insurance Coverage

Application to: American Family Life Assurance Company of Columbus (Aflac)
[Worldwide Headquarters • Columbus, Georgia 31999]

❑ New
❑ Conversion
Policy Number:

Please Print in Black Ink – To Be Completed by Proposed Insured/Employee

Proposed Insured's/Employee's Name _____ _____ _____
Last First MI

State of Birth_____ DOB _____ Sex _____ Height _____ Weight _____
Month/Day/Year

SSN _____ - _____ - _____
(optional)

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP_____

Home Telephone (___)_____ Business Telephone (___)_____ Best Time to Call _____

E-Mail Address (optional)_____

Are you applying for Dependent Child(ren) coverage? ❑ Yes ❑ No
If Yes, Dependent Children must be under age 25 at the time of application.

Write spouse's name below if you are applying for Two-Parent Family or Named Insured/Spouse Only coverage; if you have no spouse or your spouse is not to be covered, put N/A in the space below.

Spouse's Name _____ _____ _____ DOB _____ Sex _____
Last First MI Month/Day/Year

Payroll Account Name_____ Payroll Account No._____

Name of Employer _____

Is this insurance intended to replace any other health insurance now in force? ❑ Yes ❑ No
If Yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable, and provide the policy number here: _____

Does anyone to be covered have any other Specified Health Event coverage with Aflac? ❑ Yes ❑ No
If Yes, this must be a conversion of that coverage. Please give current policy number and see Applicant's Statements and Agreements concerning conversions.
Policy Number: _____

Does anyone to be covered under the Lump Sum Cancer Benefit Rider have any other Cancer coverage with Aflac? ❑ Yes ❑ No
If Yes, this must be a conversion of that coverage. Please give current policy number and see Applicant's Statements and Agreements concerning conversions. ❑ N/A
Policy Number: _____

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Check Coverage Desired:	[❑ Individual	❑ Named Insured/ Spouse Only	❑ One-Parent Family	❑ Two-Parent Family

	Total No. Units	**Benefit Amount**	**Premium**	
❑ Lump Sum Critical Illness Policy (Series A72100) *Total number of units are limited to [2 to 20] units at $5,000 per unit				☒ After-Tax
Optional Riders:				
❑ Lump Sum Cancer Benefit Rider (Series A72050) **Internal Cancer Benefit Amount will be the same as the Major Critical Illness Event Benefit amount selected.**				
❑ Return of Premium Benefit Rider (Series A72051) Options: ❑ No Rider ❑ New Rider ❑ Retain Current Rider (Factor amt. _____)				
❑ Sudden Cardiac Death Benefit Rider (Series A72052) **Sudden Cardiac Death Benefit Amount will be the same as the Major Critical Illness Event Benefit amount selected.**				
		Total Premium]		

Billing Method:
❑ Payroll Deduction
❑ Bank Draft (B/D, ACH)
❑ Credit Card (C/C)

Mode:
❑ 01 Weekly
❑ 01 14-Day Biweekly
❑ 01 Semimonthly
❑ 01 28-Day Biweekly
❑ 01 Monthly
❑ 03 Quarterly
❑ 06 Semiannual
❑ 12 Annual

PLEASE NOTE: If B/D, ACH, or C/C billing method is checked, only the following modes of payment are available: Monthly, Quarterly, Semiannual, or Annual.

Employee No. _____ Dept. No. _____ Assoc./Agent's No. _____

Billable Premium $ _____ Premium Collected $ _____ Sit. Code _____

APPLICANT'S STATEMENTS AND AGREEMENTS:

- I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters. It is not the date I signed this application.
- I understand that the policy I am applying for will not cover any person who has attained age 71 before the Effective Date of the policy. The policy is guaranteed renewable for your lifetime.
- I understand that coverage is not provided for an illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Loss caused by a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.
- I understand that unmarried Dependent Children, if any, must be under age 25 at the time of application. Once covered, Dependent Children will continue to be covered until the anniversary date of the policy following their 25th birthday.

- I acknowledge receipt of, if applicable:
  - ❑ Replacement Notice
  - ❑ Outline of Coverage
  - ❑ *Guide To Health Insurance for People with Medicare*

- If this is an application for a conversion of coverage, the following conditions will apply: (1) If anyone covered under the previous policy is not eligible for coverage under the new policy, the policy for which this application is made for the person(s) identified will be void, and coverage will continue for this person only under the terms of the previous policy, if such policy remains in force; (2) The Time Limit on Certain Defenses provision will run from the Effective Date of the new policy, and the original policy will be terminated as of the Effective Date of the new policy; and (3) The Pre-existing Condition Limitations in the new policy will run from the original policy's Effective Date for the benefits provided under the original policy. For the increased benefit amount, the Pre-existing Condition Limitations in the new policy will run from the new policy's Effective Date.

- I understand that (1) the policy of insurance I am now applying for will be issued based upon the written answers to the questions and information asked for in this application and any other pertinent information Aflac may require for proper underwriting; (2) the policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (3) no change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.

- I understand that (1) Aflac is not bound by any statement made by me, or any associate/agent of Aflac, unless written herein and (2) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing.

- I understand that the premium amount listed on this application represents the premium amount that my employer will remit to Aflac on my behalf. I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me on an online enrollment system, if applicable.

- If I am applying to replace existing Aflac coverage with this policy, I acknowledge that the policies may have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current Aflac policy and its benefits for the benefits provided in this Aflac policy.

  Proposed Insured's Initials _____

- I have reviewed the statements and answers I have provided on this application. I understand that this policy is to be issued based upon these statements and answers, and any other pertinent information Aflac may require for proper underwriting. The answers are complete and true. I understand that all statements made in this application are deemed representations and not warranties but that material misrepresentations herein may result in loss of coverage under this policy. I further understand that I am signing this application one time even though I may have used it to apply for more than one policy. No person to be insured is covered by any Title XIX programs such as Medicaid.

- I understand that the purchase of this policy is intended to supplement my existing comprehensive health care coverage. It is not intended to replace or be issued in lieu of that coverage.

NOTICE OF INFORMATION PRACTICES

To issue an insurance policy, Aflac may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by Aflac may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you except information that relates to a claim or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our worldwide headquarters. This notice applies only in Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia.

INFORMATION REGARDING THE MEDICAL INFORMATION BUREAU (MIB)
PRENOTICE

Information regarding your insurability will be treated as confidential. Aflac may, however, make a brief report thereon to MIB, Inc., formerly known as the Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB toll-free at [1-866-692-6901 (TTY 1-866-346-3642)]. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734].

Aflac may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its Web site at www.mib.com.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus (Aflac) or any person or entity acting on its part: any medical professional, medical care institution, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), MIB, Inc., formerly known as the Medical Information Bureau, consumer reporting agency, or employer.

"Information" means facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, driving record, or any other medical or nonmedical facts that Aflac deems appropriate to determine eligibility for insurance or to evaluate a claim for benefits during the time this authorization is valid. I also authorize Aflac to give information to MIB, Inc.

I understand that any disclosure of health information to Aflac for the purpose of determining eligibility for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be redisclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Aflac for enrollment or to determine eligibility for insurance or for underwriting or risk rating (where applicable) purposes and, should coverage be issued, the information may be used to contest a claim for benefits or the issuance of the policy itself during the contestability period provided in the policy.

I understand that Aflac is conditioning the issuance of coverage on the provision of this authorization, and that, while I may refuse to sign this authorization, my refusal to do so could result in coverage not being issued.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac has taken action in reliance on this authorization or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac, [Attn: Policy Service, 1932 Wynnton Road, Columbus, GA 31999].

Unless otherwise revoked, I agree that this authorization will expire on the earlier of the date Aflac notifies me of its declination of my application for coverage or, if a policy is issued, two years from the policy effective date.

I agree that a copy of this authorization is as valid as the original.

For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

* hospitalization
* physician services
* hospice
* outpatient prescription drugs if you are enrolled in Medicare Part D
* other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

* Check the coverage in **all** health insurance policies you already have.
* For more information about Medicare and Medicare Supplement insurance, review the *Choosing a Medigap Policy:* A *Guide to Health Insurance for People with Medicare*, available from the insurance company.
* For help in understanding your health insurance, contact your state insurance department (website = www.accessarkansas.org/insurance) or state health insurance assistance program (SHIP Division of Department at 800-224-6330 or email *Insurance.Seniors@Arkansas.gov*).

Payroll

LUMP SUM CANCER INSURANCE POLICY (A72200 Series)
Supplemental Health Insurance Coverage

Application to: American Family Life Assurance Company of Columbus (Aflac)
[Worldwide Headquarters • Columbus, Georgia 31999]

❑ New
❑ Conversion
Policy Number:

Please Print in Black Ink – To Be Completed by Proposed Insured/Employee

Proposed Insured's/Employee's Name _____ _____ _____
Last First MI

State of Birth_____ DOB _____ Sex _____
Month/Day/Year

SSN _____ - _____ - _____
(optional)

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP_____

Home Telephone (___)_____ Business Telephone (___)_____ Best Time to Call _____

E-Mail Address (optional)_____

Are you applying for Dependent Child(ren) coverage? ❑ Yes ❑ No
If Yes, Dependent Children must be under age 25 at the time of application.

Write spouse's name below if you are applying for Two-Parent Family or Named Insured/Spouse Only coverage; if you have no spouse or your spouse is not to be covered, put N/A in the space below.

Spouse's Name _____ _____ _____ DOB _____ Sex _____
Last First MI Month/Day/Year

Payroll Account Name _____ Payroll Account No. _____

Name of Employer _____

Is this insurance intended to replace any other health insurance now in force? ❑ Yes ❑ No
If Yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable, and provide the policy number here: _____

Does anyone to be covered have any other Cancer coverage with Aflac? ❑ Yes ❑ No
If Yes, this must be a conversion of that coverage. Please give current policy number and see Applicant's Statements and Agreements concerning conversions.
Policy Number: _____

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Check Coverage Desired:	[❑ Individual	❑ Named Insured/ Spouse Only	❑ One-Parent Family	❑ Two-Parent Family

	Total No. Units	**Benefit Amount**	**Premium**	
❑ **Lump Sum Cancer Policy (Series A72200)** ***Total number of units are limited to [2 to 20] units at $5,000 per unit**				☒ After-Tax
Optional Rider:				
❑ **Return of Premium Benefit Rider (Series A72051)** **Options:** ❑ No Rider ❑ New Rider ❑ Retain Current Rider (Factor amt. _____)				
		Total Premium]		

Billing Method:
- ❑ Payroll Deduction
- ❑ Bankdraft (B/D, ACH)
- ❑ Credit Card (C/C)

Mode:
- ❑ 01 Weekly
- ❑ 01 14-Day Biweekly
- ❑ 01 28-Day Biweekly
- ❑ 01 Semimonthly
- ❑ 01 Monthly
- ❑ 03 Quarterly
- ❑ 06 Semiannual
- ❑ 12 Annual

PLEASE NOTE: If B/D, ACH, or C/C billing method is checked, only the following modes of payment are available: Monthly, Quarterly, Semiannual, or Annual.

Employee No. _____ Dept. No. _____ Assoc./Agent's No. _____

Billable Premium $ _____ Premium Collected $ _____ Sit. Code _____

APPLICANT'S STATEMENTS AND AGREEMENTS:

- I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters. It is not the date I signed this application.
- I understand that the policy I am applying for will not cover any person who has attained age 71 before the Effective Date of the policy. The policy is guaranteed renewable for your lifetime.
- I understand that coverage is not provided for an illness, disease, infection, or disorder for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Loss caused by a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.
- I understand that unmarried Dependent Children, if any, must be under age 25 at the time of application. Once covered, Dependent Children will continue to be covered until the anniversary date of the policy following their 25th birthday.
- I acknowledge receipt of, if applicable:
  - ❑ Replacement Notice
  - ❑ Outline of Coverage
  - ❑ *Guide To Health Insurance for People with Medicare*
- If this is an application for a conversion of coverage, the following conditions will apply: (1) If anyone covered under the previous policy is not eligible for coverage under the new policy, the policy for which this application is made for the person(s) identified will be void, and coverage will continue for this person only under the terms of the previous policy, if such policy remains in force; (2) The Time Limit on Certain Defenses provision will run from the Effective Date of the new policy, and the original policy will be terminated as of the Effective Date of the new policy; and (3) The Pre-existing Condition Limitations in the new policy will run from the original policy's Effective Date for the benefits provided under the original policy. For the increased benefit amount, the Pre-existing Condition Limitations in the new policy will run from the new policy's Effective Date.

- I understand that (1) the policy of insurance I am now applying for will be issued based upon the written answers to the questions and information asked for in this application and any other pertinent information Aflac may require for proper underwriting; (2) the policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (3) no change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.
- I understand that (1) Aflac is not bound by any statement made by me, or any associate/agent of Aflac, unless written herein and (2) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing.
- I understand that the premium amount listed on this application represents the premium amount that my employer will remit to Aflac on my behalf. I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me on an online enrollment system, if applicable.
- If I am applying to replace existing Aflac coverage with this policy, I acknowledge that the policies may have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current Aflac policy and its benefits for the benefits provided in this Aflac policy.

  Proposed Insured's Initials _____
- I have reviewed the statements and answers I have provided on this application. I understand that this policy is to be issued based upon these statements and answers, and any other pertinent information Aflac may require for proper underwriting. The answers are complete and true. I understand that all statements made in this application are deemed representations and not warranties but that material misrepresentations herein may result in loss of coverage under this policy. I further understand that I am signing this application one time even though I may have used it to apply for more than one policy. No person to be insured is covered by any Title XIX programs such as Medicaid.
- I understand that the purchase of this policy is intended to supplement my existing comprehensive health care coverage. It is not intended to replace or be issued in lieu of that coverage.

NOTICE OF INFORMATION PRACTICES

To issue an insurance policy, Aflac may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by Aflac may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you except information that relates to a claim or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our worldwide headquarters. This notice applies only in Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia.

INFORMATION REGARDING THE MEDICAL INFORMATION BUREAU (MIB)
PRENOTICE

Information regarding your insurability will be treated as confidential. Aflac may, however, make a brief report thereon to MIB, Inc., formerly known as the Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB toll-free at [1-866-692-6901 (TTY 1-866-346-3642)]. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734].

Aflac may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its Web site at www.mib.com.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus (Aflac) or any person or entity acting on its part: any medical professional, medical care institution, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), MIB, Inc., formerly known as the Medical Information Bureau, consumer reporting agency, or employer.

"Information" means facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, driving record, or any other medical or non-medical facts that Aflac deems appropriate to determine eligibility for insurance or to evaluate a claim for benefits during the time this authorization is valid. I also authorize Aflac to give information to MIB, Inc.

I understand that any disclosure of health information to Aflac for the purpose of determining eligibility for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be re-disclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Aflac for enrollment or to determine eligibility for insurance or for underwriting or risk rating (where applicable) purposes and, should coverage be issued, the information may be used to contest a claim for benefits or the issuance of the policy itself during the contestability period provided in the policy.

I understand that Aflac is conditioning the issuance of coverage on the provision of this authorization, and that, while I may refuse to sign this authorization, my refusal to do so could result in coverage not being issued.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac has taken action in reliance on this authorization or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac, [Attn: Policy Service, 1932 Wynnton Road, Columbus, GA 31999].

Unless otherwise revoked, I agree that this authorization will expire on the earlier of the date Aflac notifies me of its declination of my application for coverage or, if a policy is issued, two years from the policy effective date.

I agree that a copy of this authorization is as valid as the original.

For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

* hospitalization
* physician services
* hospice
* outpatient prescription drugs if you are enrolled in Medicare Part D
* other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

* Check the coverage in **all** health insurance policies you already have.
* For more information about Medicare and Medicare Supplement insurance, review the *Choosing a Medigap Policy:* A *Guide to Health Insurance for People with Medicare*, available from the insurance company.
* For help in understanding your health insurance, contact your state insurance department (website = www.accessarkansas.org/insurance) or state health insurance assistance program (SHIP Division of Department at 800-224-6330 or email *Insurance.Seniors@Arkansas.gov*).

Union

LUMP SUM CRITICAL ILLNESS INSURANCE POLICY (A72100 Series)
Supplemental Health Insurance Coverage

Application to: American Family Life Assurance Company of Columbus (Aflac)
[Worldwide Headquarters • Columbus, Georgia 31999]

❑ New
❑ Conversion
Policy Number:

Please Print in Black Ink – To Be Completed by Proposed Insured

Proposed Insured's Name _____
Last First MI

State of Birth_____ DOB _____ Sex _____ Height _____ Weight _____
Month/Day/Year

SSN _____ - _____ - _____
(optional)

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP_____

Home Telephone (___)_____ Business Telephone (___)_____ Best Time to Call _____

E-Mail Address (optional)_____

Are you applying for Dependent Child(ren) coverage? ❑ Yes ❑ No
If Yes, Dependent Children must be under age 25 at the time of application.

Write spouse's name below if you are applying for Two-Parent Family or Named Insured/Spouse Only coverage; if you have no spouse or your spouse is not to be covered, put N/A in the space below.

Spouse's Name _____ DOB _____ Sex _____
Last First MI Month/Day/Year

Account Name_____ Account No._____

Name of Employer _____

Is this insurance intended to replace any other health insurance now in force? ❑ Yes ❑ No
If Yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable, and provide the policy number here: _____

Does anyone to be covered have any other Specified Health Event coverage with Aflac? ❑ Yes ❑ No
If Yes, this must be a conversion of that coverage. Please give current policy number and see Applicant's Statements and Agreements concerning conversions.
Policy Number: _____

Does anyone to be covered under the Lump Sum Cancer Benefit Rider have any other Cancer coverage with Aflac? ❑ Yes ❑ No ❑ N/A
If Yes, this must be a conversion of that coverage. Please give current policy number and see Applicant's Statements and Agreements concerning conversions.
Policy Number: _____

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Check Coverage Desired:	[❑ Individual	❑ Named Insured/ Spouse Only	❑ One-Parent Family	❑ Two-Parent Family

	Total No. Units	**Benefit Amount**	**Premium**	
❑ **Lump Sum Critical Illness Policy (Series A72100)** ***Total number of units are limited to [2 to 20] units at $5,000 per unit**				☒ After-Tax
Optional Riders:				
❑ **Lump Sum Cancer Benefit Rider (Series A72050)** **Internal Cancer Benefit Amount will be the same as the Major Critical Illness Event Benefit amount selected.**				
❑ **Return of Premium Benefit Rider (Series A72051)** **Options:** ❑ No Rider ❑ New Rider ❑ Retain Current Rider (Factor amt. _____)				
❑ **Sudden Cardiac Death Benefit Rider (Series A72052)** **Sudden Cardiac Death Benefit Amount will be the same as the Major Critical Illness Event Benefit amount selected.**				
		Total Premium]		

Billing Method:
❑ Direct
❑ List Bill
❑ Bank Draft (B/D, ACH)
❑ Credit Card (C/C)

Mode:
❑ 01 Monthly
❑ 03 Quarterly
❑ 06 Semiannual
❑ 12 Annual

Assoc./Agent No. _____ Sit. Code _____ Billable Premium $ _____ Premium Collected $ _____

TO BE COMPLETED BY PROPOSED INSURED

Are you currently working at your primary job with the employer listed on the front of this application? ❑ Yes ❑ No

If you answered No to Question 1 above, a policy will not be issued; therefore, do not submit this application.

APPLICANT'S STATEMENTS AND AGREEMENTS:

- I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters. It is not the date I signed this application.
- I understand that the policy I am applying for will not cover any person who has attained age 71 before the Effective Date of the policy. The policy is guaranteed renewable for your lifetime.
- I understand that coverage is not provided for an illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Loss caused by a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.
- I understand that unmarried Dependent Children, if any, must be under age 25 at the time of application. Once covered, Dependent Children will continue to be covered until the anniversary date of the policy following their 25th birthday.

- I acknowledge receipt of, if applicable:
  - ❑ Replacement Notice
  - ❑ Outline of Coverage
  - ❑ *Guide To Health Insurance for People with Medicare*

- If this is an application for a conversion of coverage, the following conditions will apply: (1) If anyone covered under the previous policy is not eligible for coverage under the new policy, the policy for which this application is made for the person(s) identified will be void, and coverage will continue for this person only under the terms of the previous policy, if such policy remains in force; (2) The Time Limit on Certain Defenses provision will run from the Effective Date of the new policy, and the original policy will be terminated as of the Effective Date of the new policy; and (3) The Pre-existing Condition Limitations in the new policy will run from the original policy's Effective Date for the benefits provided under the original policy. For the increased benefit amount, the Pre-existing Condition Limitations in the new policy will run from the new policy's Effective Date.

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- I understand that (1) Aflac is not bound by any statement made by me, or any associate/agent of Aflac, unless written herein and (2) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing.

- I understand that the premium amount listed on this application represents the premium amount that my employer will remit to Aflac on my behalf. I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me on an online enrollment system, if applicable.

- If I am applying to replace existing Aflac coverage with this policy, I acknowledge that the policies may have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current Aflac policy and its benefits for the benefits provided in this Aflac policy.

  Proposed Insured's Initials _____

- I have reviewed the statements and answers I have provided on this application. I understand that this policy is to be issued based upon these statements and answers, and any other pertinent information Aflac may require for proper underwriting. The answers are complete and true. I understand that all statements made in this application are deemed representations and not warranties but that material misrepresentations herein may result in loss of coverage under this policy. I further understand that I am signing this application one time even though I may have used it to apply for more than one policy. No person to be insured is covered by any Title XIX programs such as Medicaid.

- I understand that the purchase of this policy is intended to supplement my existing comprehensive health care coverage. It is not intended to replace or be issued in lieu of that coverage.

NOTICE OF INFORMATION PRACTICES

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Aflac may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its Web site at www.mib.com.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus (Aflac) or any person or entity acting on its part: any medical professional, medical care institution, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), MIB, Inc., formerly known as the Medical Information Bureau, consumer reporting agency, or employer.

"Information" means facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, driving record, or any other medical or non-medical facts that Aflac deems appropriate to determine eligibility for insurance or to evaluate a claim for benefits during the time this authorization is valid. I also authorize Aflac to give information to MIB, Inc.

I understand that any disclosure of health information to Aflac for the purpose of determining eligibility for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be re-disclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Aflac for enrollment or to determine eligibility for insurance or for underwriting or risk rating (where applicable) purposes and, should coverage be issued, the information may be used to contest a claim for benefits or the issuance of the policy itself during the contestability period provided in the policy.

I understand that Aflac is conditioning the issuance of coverage on the provision of this authorization, and that, while I may refuse to sign this authorization, my refusal to do so could result in coverage not being issued.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac has taken action in reliance on this authorization or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac, [Attn: Policy Service, 1932 Wynnton Road, Columbus, GA 31999].

Unless otherwise revoked, I agree that this authorization will expire on the earlier of the date Aflac notifies me of its declination of my application for coverage or, if a policy is issued, two years from the policy effective date.

I agree that a copy of this authorization is as valid as the original.

For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

* hospitalization
* physician services
* hospice
* outpatient prescription drugs if you are enrolled in Medicare Part D
* other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

* Check the coverage in **all** health insurance policies you already have.
* For more information about Medicare and Medicare Supplement insurance, review the *Choosing a Medigap Policy:* A *Guide to Health Insurance for People with Medicare*, available from the insurance company.
* For help in understanding your health insurance, contact your state insurance department (website = www.accessarkansas.org/insurance) or state health insurance assistance program (SHIP Division of Department at 800-224-6330 or email *Insurance.Seniors@Arkansas.gov*).

Union

LUMP SUM CANCER INSURANCE POLICY (A72200 Series)
Supplemental Health Insurance Coverage

Application to: American Family Life Assurance Company of Columbus (Aflac)
[Worldwide Headquarters • Columbus, Georgia 31999]

❑ New
❑ Conversion
Policy Number:

Please Print in Black Ink – To Be Completed by Proposed Insured

Proposed Insured's Name _____
Last First MI

State of Birth_____ DOB _____ Sex _____
Month/Day/Year

SSN _____ - _____ - _____
(optional)

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP_____

Home Telephone (___)_____ Business Telephone (___)_____ Best Time to Call _____

E-Mail Address (optional)_____

Are you applying for Dependent Child(ren) coverage? ❑ Yes ❑ No
If Yes, Dependent Children must be under age 25 at the time of application.

Write spouse's name below if you are applying for Two-Parent Family or Named Insured/Spouse Only coverage; if you have no spouse or your spouse is not to be covered, put N/A in the space below.

Spouse's Name _____ DOB _____ Sex _____
Last First MI Month/Day/Year

Account Name_____ Account No._____

Name of Employer _____

Is this insurance intended to replace any other health insurance now in force? ❑ Yes ❑ No
If Yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable, and provide the policy number here: _____

Does anyone to be covered have any other Cancer coverage with Aflac? ❑ Yes ❑ No
If Yes, this must be a conversion of that coverage. Please give current policy number and see Applicant's Statements and Agreements concerning conversions.
Policy Number: _____

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Check Coverage Desired:	[❑ Individual	❑ Named Insured/ Spouse Only	❑ One-Parent Family	❑ Two-Parent Family

	Total No. Units	**Benefit Amount**	**Premium**	
❑ **Lump Sum Cancer Policy (Series A72200)** ***Total number of units are limited to [2 to 20] units at $5,000 per unit**				☒ After-Tax
Optional Rider:				
❑ **Return of Premium Benefit Rider (Series A72051)** **Options:** ❑ No Rider ❑ New Rider ❑ Retain Current Rider (Factor amt. _____)				
		Total Premium]		

Billing Method:
❑ Direct
❑ List Bill
❑ Bank Draft (B/D, ACH)
❑ Credit Card (C/C)

Mode:
❑ 01 Monthly
❑ 03 Quarterly
❑ 06 Semiannual
❑ 12 Annual

Assoc./Agent No. _____ Sit. Code _____ Billable Premium $ _____ Premium Collected $ _____

TO BE COMPLETED BY PROPOSED INSURED

Are you currently working at your primary job with the employer listed on the front of this application? ❑ Yes ❑ No

If you answered No to Question 1 above, a policy will not be issued; therefore, do not submit this application.

APPLICANT'S STATEMENTS AND AGREEMENTS:

- I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters. It is not the date I signed this application.
- I understand that the policy I am applying for will not cover any person who has attained age 71 before the Effective Date of the policy. The policy is guaranteed renewable for your lifetime.
- I understand that coverage is not provided for an illness, disease, infection, or disorder for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Loss caused by a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.
- I understand that unmarried Dependent Children, if any, must be under age 25 at the time of application. Once covered, Dependent Children will continue to be covered until the anniversary date of the policy following their 25th birthday.
- I acknowledge receipt of, if applicable:
  ❑ Replacement Notice ❑ Outline of Coverage
  ❑ *Guide To Health Insurance for People with Medicare*
- If this is an application for a conversion of coverage, the following conditions will apply: (1) If anyone covered under the previous policy is not eligible for coverage under the new policy, the policy for which this application is made for

the person(s) identified will be void, and coverage will continue for this person only under the terms of the previous policy, if such policy remains in force; (2) The Time Limit on Certain Defenses provision will run from the Effective Date of the new policy, and the original policy will be terminated as of the Effective Date of the new policy; and (3) The Pre-existing Condition Limitations in the new policy will run from the original policy's Effective Date for the benefits provided under the original policy. For the increased benefit amount, the Pre-existing Condition Limitations in the new policy will run from the new policy's Effective Date.

- I understand that (1) the policy of insurance I am now applying for will be issued based upon the written answers to the questions and information asked for in this application and any other pertinent information Aflac may require for proper underwriting; (2) the policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (3) no change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.
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- I understand that the premium amount listed on this application represents the premium amount that my employer will remit to Aflac on my behalf. I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me on an online enrollment system, if applicable.
- If I am applying to replace existing Aflac coverage with this policy, I acknowledge that the policies may have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current Aflac policy and its benefits for the benefits provided in this Aflac policy.

  Proposed Insured's Initials _____
- I have reviewed the statements and answers I have provided on this application. I understand that this policy is to be issued based upon these statements and answers, and any other pertinent information Aflac may require for proper underwriting. The answers are complete and true. I understand that all statements made in this application are deemed representations and not warranties but that material misrepresentations herein may result in loss of coverage under this policy. I further understand that I am signing this application one time even though I may have used it to apply for more than one policy. No person to be insured is covered by any Title XIX programs such as Medicaid.
- I understand that the purchase of this policy is intended to supplement my existing comprehensive health care coverage. It is not intended to replace or be issued in lieu of that coverage.

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INFORMATION REGARDING THE MEDICAL INFORMATION BUREAU (MIB)
PRENOTICE

Information regarding your insurability will be treated as confidential. Aflac may, however, make a brief report thereon to MIB, Inc., formerly known as the Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB toll-free at [1-866-692-6901 (TTY 1-866-346-3642)]. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734].

Aflac may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its Web site at www.mib.com.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus (Aflac) or any person or entity acting on its part: any medical professional, medical care institution, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), MIB, Inc., formerly known as the Medical Information Bureau, consumer reporting agency, or employer. "Information" means facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, driving record, or any other medical or non-medical facts that Aflac deems appropriate to determine eligibility for insurance or to evaluate a claim for benefits during the time this authorization is valid. I also authorize Aflac to give information to MIB, Inc.

I understand that any disclosure of health information to Aflac for the purpose of determining eligibility for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be re-disclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Aflac for enrollment or to determine eligibility for insurance or for underwriting or risk rating (where applicable) purposes and, should coverage be issued, the information may be used to contest a claim for benefits or the issuance of the policy itself during the contestability period provided in the policy.

I understand that Aflac is conditioning the issuance of coverage on the provision of this authorization, and that, while I may refuse to sign this authorization, my refusal to do so could result in coverage not being issued.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac has taken action in reliance on this authorization or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac, [Attn: Policy Service, 1932 Wynnton Road, Columbus, GA 31999].

Unless otherwise revoked, I agree that this authorization will expire on the earlier of the date Aflac notifies me of its declination of my application for coverage or, if a policy is issued, two years from the policy effective date.

I agree that a copy of this authorization is as valid as the original.

For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

* hospitalization
* physician services
* hospice
* outpatient prescription drugs if you are enrolled in Medicare Part D
* other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

* Check the coverage in **all** health insurance policies you already have.
* For more information about Medicare and Medicare Supplement insurance, review the *Choosing a Medigap Policy:* A *Guide to Health Insurance for People with Medicare*, available from the insurance company.
* For help in understanding your health insurance, contact your state insurance department (website = www.accessarkansas.org/insurance) or state health insurance assistance program (SHIP Division of Department at 800-224-6330 or email *Insurance.Seniors@Arkansas.gov*).

Payroll

Large Account

LUMP SUM CRITICAL ILLNESS INSURANCE POLICY (A72100 Series)
Supplemental Health Insurance Coverage

Application to: American Family Life Assurance Company of Columbus (Aflac)
[Worldwide Headquarters • Columbus, Georgia 31999]

❑ New
❑ Conversion
Policy Number:

Please Print in Black Ink – To Be Completed by Proposed Insured/Employee

Proposed Insured's/Employee's Name _____ _____ _____
Last First MI

State of Birth_____ DOB _____ Sex _____ Height _____ Weight _____
Month/Day/Year

SSN _____ - _____ - _____
(optional)

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP_____

Home Telephone (___)_____ Business Telephone (___)_____ Best Time to Call _____

E-Mail Address (optional)_____

Are you applying for Dependent Child(ren) coverage? ❑ Yes ❑ No
If Yes, Dependent Children must be under age 25 at the time of application.

Write spouse's name below if you are applying for Two-Parent Family or Named Insured/Spouse Only coverage; if you have no spouse or your spouse is not to be covered, put N/A in the space below.

Spouse's Name _____ _____ _____ DOB _____ Sex _____
Last First MI Month/Day/Year

Payroll Account Name_____ Payroll Account No._____

Name of Employer _____

Is this insurance intended to replace any other health insurance now in force? ❑ Yes ❑ No
If Yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable, and provide the policy number here: _____

Does anyone to be covered have any other Specified Health Event coverage with Aflac? ❑ Yes ❑ No
If Yes, this must be a conversion of that coverage. Please give current policy number and see Applicant's Statements and Agreements concerning conversions.
Policy Number: _____

Does anyone to be covered under the Lump Sum Cancer Benefit Rider have any other Cancer coverage with Aflac? ❑ Yes ❑ No ❑ N/A
If Yes, this must be a conversion of that coverage. Please give current policy number and see Applicant's Statements and Agreements concerning conversions.
Policy Number: _____

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Check Coverage Desired:	[❑ Individual	❑ Named Insured/ Spouse Only	❑ One-Parent Family	❑ Two-Parent Family

	Total No. Units	**Benefit Amount**	**Premium**	
❑ Lump Sum Critical Illness Policy (Series A72100) *Total number of units are limited to [2 to 20] units at $5,000 per unit				☒ After-Tax
Optional Riders:				
❑ Lump Sum Cancer Benefit Rider (Series A72050) **Internal Cancer Benefit Amount will be the same as the Major Critical Illness Event Benefit amount selected.**				
❑ Return of Premium Benefit Rider (Series A72051) Options: ❑ No Rider ❑ New Rider ❑ Retain Current Rider (Factor amt. _____)				
❑ Sudden Cardiac Death Benefit Rider (Series A72052) **Sudden Cardiac Death Benefit Amount will be the same as the Major Critical Illness Event Benefit amount selected.**				
		Total Premium]		

Billing Method:

❑ Payroll Deduction
❑ Bank Draft (B/D, ACH)
❑ Credit Card (C/C)

Mode:

❑ 01 Weekly
❑ 01 14-Day Biweekly
❑ 01 Semimonthly
❑ 01 28-Day Biweekly
❑ 01 Monthly
❑ 03 Quarterly
❑ 06 Semiannual
❑ 12 Annual

PLEASE NOTE: If B/D, ACH, or C/C billing method is checked, only the following modes of payment are available: Monthly, Quarterly, Semiannual, or Annual.

Employee No. _____ Dept. No. _____ Assoc./Agent's No. _____

Billable Premium $ _____ Premium Collected $ _____ Sit. Code _____

TO BE COMPLETED BY PROPOSED INSURED/EMPLOYEE

Has anyone to be covered used tobacco products or products containing nicotine of any type in the last 12 months? This information will be verified at the time of claim. ❑ Yes ❑ No

APPLICANT'S STATEMENTS AND AGREEMENTS:

- I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters. It is not the date I signed this application.
- I understand that the policy I am applying for will not cover any person who has attained age 71 before the Effective Date of the policy. The policy is guaranteed renewable for your lifetime.
- I understand that coverage is not provided for an illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or

treatment. Loss caused by a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.

- I understand that unmarried Dependent Children, if any, must be under age 25 at the time of application. Once covered, Dependent Children will continue to be covered until the anniversary date of the policy following their 25th birthday.

- I acknowledge receipt of, if applicable:
  - ❑ Replacement Notice
  - ❑ Outline of Coverage
  - ❑ *Guide To Health Insurance for People with Medicare*

- If this is an application for a conversion of coverage, the following conditions will apply: (1) If anyone covered under the previous policy is not eligible for coverage under the new policy, the policy for which this application is made for the person(s) identified will be void, and coverage will continue for this person only under the terms of the previous policy, if such policy remains in force; (2) The Time Limit on Certain Defenses provision will run from the Effective Date of the new policy, and the original policy will be terminated as of the Effective Date of the new policy; and (3) The Pre-existing Condition Limitations in the new policy will run from the original policy's Effective Date for the benefits provided under the original policy. For the increased benefit amount, the Pre-existing Condition Limitations in the new policy will run from the new policy's Effective Date.

- I understand that (1) the policy of insurance I am now applying for will be issued based upon the written answers to the questions and information asked for in this application and any other pertinent information Aflac may require for proper underwriting; (2) the policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (3) no change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.

- I understand that (1) Aflac is not bound by any statement made by me, or any associate/agent of Aflac, unless written herein and (2) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing.

- I understand that the premium amount listed on this application represents the premium amount that my employer will remit to Aflac on my behalf. I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me on an online enrollment system, if applicable.

- If I am applying to replace existing Aflac coverage with this policy, I acknowledge that the policies may have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current Aflac policy and its benefits for the benefits provided in this Aflac policy.

  Proposed Insured's Initials _____

- I have reviewed the statements and answers I have provided on this application. I understand that this policy is to be issued based upon these statements and answers, and any other pertinent information Aflac may require for proper underwriting. The answers are complete and true. I understand that all statements made in this application are deemed representations and not warranties but that material misrepresentations herein may result in loss of coverage under this policy. I further understand that I am signing this application one time even though I may have used it to apply for more than one policy. No person to be insured is covered by any Title XIX programs such as Medicaid.

- I understand that the purchase of this policy is intended to supplement my existing comprehensive health care coverage. It is not intended to replace or be issued in lieu of that coverage.

NOTICE OF INFORMATION PRACTICES

To issue an insurance policy, Aflac may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by Aflac may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you except information that relates to a claim or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our worldwide headquarters. This notice applies only in Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia.

INFORMATION REGARDING THE MEDICAL INFORMATION BUREAU (MIB)
PRENOTICE

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Aflac may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its Web site at www.mib.com.

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"Information" means facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, driving record, or any other medical or nonmedical facts that Aflac deems appropriate to determine eligibility for insurance or to evaluate a claim for benefits during the time this authorization is valid. I also authorize Aflac to give information to MIB, Inc.

I understand that any disclosure of health information to Aflac for the purpose of determining eligibility for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be redisclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Aflac for enrollment or to determine eligibility for insurance or for underwriting or risk rating (where applicable) purposes and, should coverage be issued, the information may be used to contest a claim for benefits or the issuance of the policy itself during the contestability period provided in the policy.

I understand that Aflac is conditioning the issuance of coverage on the provision of this authorization, and that, while I may refuse to sign this authorization, my refusal to do so could result in coverage not being issued.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac has taken action in reliance on this authorization or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac, [Attn: Policy Service, 1932 Wynnton Road, Columbus, GA 31999].

Unless otherwise revoked, I agree that this authorization will expire on the earlier of the date Aflac notifies me of its declination of my application for coverage or, if a policy is issued, two years from the policy effective date.

I agree that a copy of this authorization is as valid as the original.

For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

* hospitalization
* physician services
* hospice
* outpatient prescription drugs if you are enrolled in Medicare Part D
* other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

* Check the coverage in **all** health insurance policies you already have.
* For more information about Medicare and Medicare Supplement insurance, review the *Choosing a Medigap Policy:* A *Guide to Health Insurance for People with Medicare*, available from the insurance company.
* For help in understanding your health insurance, contact your state insurance department (website = www.accessarkansas.org/insurance) or state health insurance assistance program (SHIP Division of Department at 800-224-6330 or email *Insurance.Seniors@Arkansas.gov*).

Payroll

Large Account

LUMP SUM CANCER INSURANCE POLICY (A72200 Series)
Supplemental Health Insurance Coverage
Application to: American Family Life Assurance Company of Columbus (Aflac)
[Worldwide Headquarters • Columbus, Georgia 31999]

❑ New
❑ Conversion
Policy Number:

Please Print in Black Ink – To Be Completed by Proposed Insured/Employee

Proposed Insured's/Employee's Name _____ _____ _____
Last First MI

State of Birth_____ DOB _____ Sex _____
Month/Day/Year

SSN. _____ - _____ - _____
(optional)

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP_____

Home Telephone (___)_____ Business Telephone (___)_____ Best Time to Call _____

E-Mail Address (optional)_____

Are you applying for Dependent Child(ren) coverage? ❑ Yes ❑ No
If Yes, Dependent Children must be under age 25 at the time of application.

Write spouse's name below if you are applying for Two-Parent Family or Named Insured/Spouse Only coverage; if you have no spouse or your spouse is not to be covered, put N/A in the space below.

Spouse's Name _____ _____ _____ DOB _____ Sex _____
Last First MI Month/Day/Year

Payroll Account Name _____ Payroll Account No. _____

Name of Employer _____

Is this insurance intended to replace any other health insurance now in force? ❑ Yes ❑ No
If Yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable, and provide the policy number here: _____

Does anyone to be covered have any other Cancer coverage with Aflac? ❑ Yes ❑ No
If Yes, this must be a conversion of that coverage. Please give current policy number and see Applicant's Statements and Agreements concerning conversions.
Policy Number: _____

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Check Coverage Desired:	[❑ Individual	❑ Named Insured/ Spouse Only	❑ One-Parent Family	❑ Two-Parent Family

	Total No. Units	**Benefit Amount**	**Premium**	
❑ **Lump Sum Cancer Policy (Series A72200)** ***Total number of units are limited to [2 to 20] units at $5,000 per unit**				☒ After-Tax
Optional Rider:				
❑ **Return of Premium Benefit Rider (Series A72051)** **Options:** ❑ No Rider ❑ New Rider ❑ Retain Current Rider (Factor amt. _____)				
		Total Premium]		

Billing Method:
- ❑ Payroll Deduction
- ❑ Bankdraft (B/D, ACH)
- ❑ Credit Card (C/C)

Mode:
- ❑ 01 Weekly
- ❑ 01 14-Day Biweekly
- ❑ 01 28-Day Biweekly
- ❑ 01 Semimonthly
- ❑ 01 Monthly
- ❑ 03 Quarterly
- ❑ 06 Semiannual
- ❑ 12 Annual

PLEASE NOTE: If B/D, ACH, or C/C billing method is checked, only the following modes of payment are available: Monthly, Quarterly, Semiannual, or Annual.

Employee No. _____ Dept. No. _____ Assoc./Agent's No. _____

Billable Premium $ _____ Premium Collected $ _____ Sit. Code _____

TO BE COMPLETED BY PROPOSED INSURED/EMPLOYEE

Has anyone to be covered used tobacco products or products containing nicotine of any type in the last 12 months? This information will be verified at the time of claim. ❑ Yes ❑ No

APPLICANT'S STATEMENTS AND AGREEMENTS:

- I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters. It is not the date I signed this application.
- I understand that the policy I am applying for will not cover any person who has attained age 71 before the Effective Date of the policy. The policy is guaranteed renewable for your lifetime.
- I understand that coverage is not provided for an illness, disease, infection, or disorder for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Loss caused by a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.
- I understand that unmarried Dependent Children, if any, must be under age 25 at the time of application. Once covered, Dependent Children will continue to be covered until the anniversary date of the policy following their 25th birthday.
- I acknowledge receipt of, if applicable:
  - ❑ Replacement Notice
  - ❑ Outline of Coverage
  - ❑ *Guide To Health Insurance for People with Medicare*

- If this is an application for a conversion of coverage, the following conditions will apply: (1) If anyone covered under the previous policy is not eligible for coverage under the new policy, the policy for which this application is made for the person(s) identified will be void, and coverage will continue for this person only under the terms of the previous policy, if such policy remains in force; (2) The Time Limit on Certain Defenses provision will run from the Effective Date of the new policy, and the original policy will be terminated as of the Effective Date of the new policy; and (3) The Pre-existing Condition Limitations in the new policy will run from the original policy's Effective Date for the benefits provided under the original policy. For the increased benefit amount, the Pre-existing Condition Limitations in the new policy will run from the new policy's Effective Date.

- I understand that (1) the policy of insurance I am now applying for will be issued based upon the written answers to the questions and information asked for in this application and any other pertinent information Aflac may require for proper underwriting; (2) the policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (3) no change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.

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- I understand that the premium amount listed on this application represents the premium amount that my employer will remit to Aflac on my behalf. I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me on an online enrollment system, if applicable.

- If I am applying to replace existing Aflac coverage with this policy, I acknowledge that the policies may have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current Aflac policy and its benefits for the benefits provided in this Aflac policy.

  Proposed Insured's Initials _____

- I have reviewed the statements and answers I have provided on this application. I understand that this policy is to be issued based upon these statements and answers, and any other pertinent information Aflac may require for proper underwriting. The answers are complete and true. I understand that all statements made in this application are deemed representations and not warranties but that material misrepresentations herein may result in loss of coverage under this policy. I further understand that I am signing this application one time even though I may have used it to apply for more than one policy. No person to be insured is covered by any Title XIX programs such as Medicaid.

- I understand that the purchase of this policy is intended to supplement my existing comprehensive health care coverage. It is not intended to replace or be issued in lieu of that coverage.

NOTICE OF INFORMATION PRACTICES

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"Information" means facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, driving record, or any other medical or non-medical facts that Aflac deems appropriate to determine eligibility for insurance or to evaluate a claim for benefits during the time this authorization is valid. I also authorize Aflac to give information to MIB, Inc.

I understand that any disclosure of health information to Aflac for the purpose of determining eligibility for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be re-disclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Aflac for enrollment or to determine eligibility for insurance or for underwriting or risk rating (where applicable) purposes and, should coverage be issued, the information may be used to contest a claim for benefits or the issuance of the policy itself during the contestability period provided in the policy.

I understand that Aflac is conditioning the issuance of coverage on the provision of this authorization, and that, while I may refuse to sign this authorization, my refusal to do so could result in coverage not being issued.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac has taken action in reliance on this authorization or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac, [Attn: Policy Service, 1932 Wynnton Road, Columbus, GA 31999].

Unless otherwise revoked, I agree that this authorization will expire on the earlier of the date Aflac notifies me of its declination of my application for coverage or, if a policy is issued, two years from the policy effective date.

I agree that a copy of this authorization is as valid as the original.

For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
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Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

* hospitalization
* physician services
* hospice
* outpatient prescription drugs if you are enrolled in Medicare Part D
* other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

* Check the coverage in **all** health insurance policies you already have.
* For more information about Medicare and Medicare Supplement insurance, review the *Choosing a Medigap Policy:* A *Guide to Health Insurance for People with Medicare*, available from the insurance company.
* For help in understanding your health insurance, contact your state insurance department (website = www.accessarkansas.org/insurance) or state health insurance assistance program (SHIP Division of Department at 800-224-6330 or email *Insurance.Seniors@Arkansas.gov*).

American Family Life Assurance Company of Columbus (Aflac)
[Worldwide Headquarters: Columbus, Georgia 31999]

PAYROLL – ❑ LUMP SUM CRITICAL ILLNESS

PLEASE COMPLETE THE FOLLOWING QUESTIONS
IF YOU ARE APPLYING FOR THE LUMP SUM CRITICAL ILLNESS POLICY

1. Has anyone to be covered used tobacco products or products containing nicotine of any type in the last 12 months? ❑ Yes ❑ No
   If yes, you are eligible to apply for a maximum of $20,000 (4 units) of coverage. This information will be verified at the time of claim.

2. Has anyone to be covered been to see a member of the medical profession about a medical condition that has yet to be diagnosed? ❑ Yes ❑ No
   If yes, you are eligible to apply for a maximum of $20,000 (4 units) of coverage.

If Question 1 or 2 is answered Yes, was it the:

❑ Proposed Insured/Employee ❑ Spouse ❑ Child

_____
Name of person(s)

You are eligible to apply for a maximum of $20,000 (4 units) of coverage.

3. Does anyone to be covered have any condition for which any medical procedure (including but not limited to surgery, child delivery, organ or bone marrow transplant) has been planned or the possibility of which has been discussed with medical personnel? ❑ Yes ❑ No

4. Does anyone to be covered currently have or in the last 12 months, has anyone to be covered been diagnosed with or treated for any of the following conditions or had any of the following procedures: ❑ Yes ❑ No

Systemic lupus	irregular heart beat
pulmonary hypertension	chest pains
cystic fibrosis	vascular insufficiency (circulatory problems)
uncontrolled hypertension/high blood pressure	renal hypertension
tachycardia	diabetes (Type II) diagnosed prior to age 30

5. Within the last 5 years has anyone to be covered been diagnosed with or treated for any of the following conditions or had any of the following procedures: ❑ Yes ❑ No

heart attack	pulmonary fibrosis
cardiomyopathy	diabetes and used tobacco after diagnosis
bypass/stents/angioplasty	diabetes treated with insulin
atrial fibrillation	diabetes with complications to include nephropathy;
implant of pacemaker/defibrillator	neuropathy; or retinopathy
heart surgery (including valve replacement	kidney disease or disorder (not including stones)
or correction)	liver disease or disorder (excluding Hepatitis A)
congestive heart failure	the administration of chemotherapy
stroke/TIA	sarcoidosis
chronic obstructive pulmonary disease (COPD)	alcohol or drug abuse
emphysema	

If any one of Questions 3 – 5 is answered Yes, was it the:

❑ Proposed Insured/Employee ❑ Spouse ❑ Child

_____
Name of person(s)

Any person(s) indicated above will not be covered under this policy. If the Proposed Insured/Employee, a policy will not be issued; therefore, do not submit this application.
If a Child, are there other children to be covered? ❑Yes ❑ No

**PLEASE COMPLETE THE FOLLOWING QUESTION
IF YOU ARE APPLYING FOR MORE THAN $20,000 (4 UNITS) OF COVERAGE.
Additional underwriting may be required.**

6. During the last 6 months, have you received any medical treatment, including injections, or been prescribed or taken medications (other than prescription contraceptives)? ❑ Yes ❑ No
If yes, please provide descriptive information below.

Medical Conditions/Treatments	Onset (mo/yr)	Surgery Performed? (If yes, provide the type of procedure and date)	Date Last Treated	Released by Physician	For Hypertension and Diabetes, List the Average Reading (for the last three months)
				❑Yes ❑No	
				❑Yes ❑No	
				❑Yes ❑No	
				❑Yes ❑No	
				❑Yes ❑No	
				❑Yes ❑No	

Medication Name	Dosage	Date First Prescribed	Medical Condition

**PLEASE COMPLETE THE FOLLOWING QUESTIONS
IF YOU ARE APPLYING FOR THE LUMP SUM CANCER BENEFIT RIDER**

7. Has anyone to be covered been to see a member of the medical profession about a medical condition that has yet to be diagnosed? ❑ Yes ❑ No

8. Within the last 5 years has anyone to be covered been diagnosed with or treated for any of the following conditions or had any of the following procedures: ❑ Yes ❑ No

Internal cancer (including myelodysplastic blood disorder and myeloproliferative blood disorder)
Melanoma (Clark's Level III or higher or a Breslow Level greater than 1.5 mm.)
Carcinoma In Situ

If Question 7 or 8 is answered Yes, was it the:

❑ Proposed Insured/Employee ❑ Spouse ❑ Child

_____
Name of person(s)

Any person(s) indicated above will not be covered under this rider.
If the Proposed Insured/Employee, this rider will not be issued.

If a Child, are there other children to be covered? ❑Yes ❑ No

9. Has anyone to be covered had Internal Cancer that was diagnosed or last treated over five years ago? ❑ Yes ❑ No
If yes, you are eligible to apply for a maximum of $20,000 (4 units) of coverage. This information will be verified at the time of claim.

If Question 9 is answered Yes, was it the:

❑ Proposed Insured/Employee ❑ Spouse ❑ Child

_____
Name of person(s)

You are eligible to apply for a maximum of $20,000 (4 units) of coverage.

American Family Life Assurance Company of Columbus (Aflac)
[Worldwide Headquarters: Columbus, Georgia 31999]

PAYROLL – FOR LARGE ACCOUNT ONLY
❑ LUMP SUM CRITICAL ILLNESS

PLEASE COMPLETE THE FOLLOWING QUESTION
IF YOU ARE APPLYING FOR THE LUMP SUM CRITICAL ILLNESS POLICY

1. Within the last 24 months, (excluding routine childbirth), has anyone to be covered been (a) out of work due to sickness or injury more than 5 consecutive days; (b) in a hospital or emergency room (ER) for more than 24 hours for sickness; (c) diagnosed or treated for hypertension or diabetes; or is anyone to be covered currently disabled due to sickness or injury? ❑ Yes ❑ No

PLEASE COMPLETE THE FOLLOWING QUESTIONS
IF QUESTION 1 IS ANSWERED YES OR YOU ARE APPLYING FOR
MORE THAN $20,000 (4 UNITS) OF COVERAGE.

2. Does anyone to be covered have any condition for which any medical procedure (including but not limited to surgery, child delivery, organ or bone marrow transplant) has been planned or the possibility of which has been discussed with medical personnel? ❑ Yes ❑ No

3. Does anyone to be covered currently have or in the last 12 months, has anyone to be covered been diagnosed with or treated for any of the following conditions or had any of the following procedures: ❑ Yes ❑ No

Systemic lupus
pulmonary hypertension
cystic fibrosis
uncontrolled hypertension/high blood pressure
tachycardia
irregular heart beat
chest pains
vascular insufficiency (circulatory problems)
renal hypertension
diabetes (Type II) diagnosed prior to age 30

4. Within the last 5 years has anyone to be covered been diagnosed with or treated for any of the following conditions or had any of the following procedures: ❑ Yes ❑ No

heart attack
cardiomyopathy
bypass/stents/angioplasty
atrial fibrillation
implant of pacemaker/defibrillator
heart surgery (including valve replacement or correction)
congestive heart failure
stroke/TIA
chronic obstructive pulmonary disease (COPD)
emphysema
pulmonary fibrosis
diabetes and used tobacco after diagnosis
diabetes treated with insulin
diabetes with complications to include nephropathy; neuropathy; or retinopathy
kidney disease or disorder (not including stones)
liver disease or disorder (excluding Hepatitis A)
the administration of chemotherapy
sarcoidosis
alcohol or drug abuse

If any one of Questions 2 – 4 is answered Yes, was it the:

❑ Proposed Insured/Employee ❑ Spouse ❑ Child

_____
Name of person(s)

If spouse or child is indicated above, he/she will not be covered under the policy. If the Proposed Insured/Employee, a policy will not be issued; therefore, do not submit this application.
If a Child, are there other children to be covered? ❑Yes ❑ No

PLEASE COMPLETE THE FOLLOWING QUESTION
IF YOU ARE APPLYING FOR MORE THAN $20,000 (4 UNITS) OF COVERAGE.
Additional underwriting may be required.

5. During the last 6 months, have you received any medical treatment, including injections, or been prescribed or taken medications (other than prescription contraceptives)? ❑ Yes ❑ No
   If yes, please provide descriptive information below.

Medical Conditions/Treatments	Onset (mo/yr)	Surgery Performed? (If yes, provide the type of procedure and date)	Date Last Treated	Released by Physician	For Hypertension and Diabetes, List the Average Reading (for the last three months)
				❑Yes ❑No	
				❑Yes ❑No	
				❑Yes ❑No	
				❑Yes ❑No	
				❑Yes ❑No	
				❑Yes ❑No	

Medication Name	Dosage	Date First Prescribed	Medical Condition

PLEASE COMPLETE THE FOLLOWING QUESTIONS
IF YOU ARE APPLYING FOR THE LUMP SUM CANCER BENEFIT RIDER

6. Has anyone to be covered been to see a member of the medical profession about a medical condition that has yet to be diagnosed? ❑ Yes ❑ No

7. Within the last 5 years has anyone to be covered been diagnosed with or treated for any of the following conditions or had any of the following procedures: ❑ Yes ❑ No

   Internal cancer (including myelodysplastic blood disorder and myeloproliferative blood disorder)
   Melanoma (Clark's Level III or higher or a Breslow Level greater than 1.5 mm.)
   Carcinoma In Situ

If Question 6 or 7 is answered Yes, was it the:

❑ Proposed Insured/Employee ❑ Spouse ❑ Child

_____
Name of person(s)

Any person(s) indicated above will not be covered under this rider.
If the Proposed Insured/Employee, this rider will not be issued.
If a Child, are there other children to be covered? ❑Yes ❑ No

8. Has anyone to be covered had Internal Cancer that was diagnosed or last treated over five years ago? ❑ Yes ❑ No
   If yes, you are eligible to apply for a maximum of $20,000 (4 units) of coverage. This information will be verified at the time of claim.

If Question 8 is answered Yes, was it the:

❑ Proposed Insured/Employee ❑ Spouse ❑ Child

_____
Name of person(s)

You are eligible to apply for a maximum of $20,000 (4 units) of coverage.

American Family Life Assurance Company of Columbus (Aflac)
[Worldwide Headquarters: Columbus, Georgia 31999]

PAYROLL – ❑ LUMP SUM CANCER

PLEASE COMPLETE THE FOLLOWING QUESTIONS
IF YOU ARE APPLYING FOR THE LUMP SUM CANCER POLICY

1. Has anyone to be covered been to see a member of the medical profession about a medical condition that has yet to be diagnosed? ❑ Yes ❑ No

2. Within the last 5 years has anyone to be covered been diagnosed with or treated for any of the following conditions or had any of the following procedures: ❑ Yes ❑ No

   Internal cancer (including myelodysplastic blood disorder and myeloproliferative blood disorder)
   Melanoma (Clark's Level III or higher or a Breslow Level greater than 1.5 mm.)
   Carcinoma In Situ

If Question 1 or 2 is answered Yes, was it the:

❑ Proposed Insured/Employee ❑ Spouse ❑ Child

_____
Name of person(s)

Any person(s) indicated above will not be covered under this policy. If the Proposed Insured/Employee, a policy will not be issued; therefore, do not submit this application.

If a Child, are there other children to be covered? ❑Yes ❑ No

3. Has anyone to be covered used tobacco products or products containing nicotine of any type in the last 12 months? ❑ Yes ❑ No
   If yes, you are eligible to apply for a maximum of $20,000 (4 units) of the Internal Cancer Benefit.
   This information will be verified at the time of claim.

4. Has anyone to be covered had Internal Cancer that was diagnosed or last treated over five years ago? ❑ Yes ❑ No
   If yes, you are eligible to apply for a maximum of $20,000 (4 units) of the Internal Cancer Benefit.
   This information will be verified at the time of claim.

If Question 3 or 4 is answered Yes, was it the:

❑ Proposed Insured/Employee ❑ Spouse ❑ Child

_____
Name of person(s)

You are eligible to apply for a maximum of $20,000 (4 units) of the Internal Cancer Benefit.

PAYROLL – FOR LARGE ACCOUNT ONLY
❑ LUMP SUM CANCER

PLEASE COMPLETE THE FOLLOWING QUESTIONS
IF YOU ARE APPLYING FOR THE LUMP SUM CANCER POLICY

1. Has anyone to be covered been to see a member of the medical profession about a medical condition that has yet to be diagnosed? ❑ Yes ❑ No

2. Within the last 5 years has anyone to be covered been diagnosed with or treated for any of the following conditions or had any of the following procedures: ❑ Yes ❑ No

   Internal cancer (including myelodysplastic blood disorder and myeloproliferative blood disorder)
   Melanoma (Clark's Level III or higher or a Breslow Level greater than 1.5 mm.)
   Carcinoma In Situ

If Question 1 or 2 is answered Yes, was it the:

❑ Proposed Insured/Employee ❑ Spouse ❑ Child

_____
Name of person(s)

Any person(s) indicated above will not be covered under this policy. If the Proposed Insured/Employee, a policy will not be issued; therefore, do not submit this application.
If a Child, are there other children to be covered? ❑Yes ❑ No

3. Has anyone to be covered had Internal Cancer that was diagnosed or last treated over five years ago? ❑ Yes ❑ No
   If yes, you are eligible to apply for a maximum of $20,000 (4 units) of the Internal Cancer Benefit. This information will be verified at the time of claim.

If Question 3 is answered Yes, was it the:

❑ Proposed Insured/Employee ❑ Spouse ❑ Child

_____
Name of person(s)

You are eligible to apply for a maximum of $20,000 (4 units) of the Internal Cancer Benefit.

REQUEST FOR ADDITIONS/APPLICATION FOR REINSTATEMENT
LUMP SUM CRITICAL ILLNESS INSURANCE FOR A72100 SERIES
LUMP SUM CANCER INSURANCE FOR A72200 SERIES
American Family Life Assurance Company of Columbus (Aflac)
[Worldwide Headquarters: Columbus, GA 31999
For information, call toll-free 1-800-99-AFLAC (1-800-992-3522)]

Name of Policyholder _____ SSN _____ (Optional)

Policy Number _____ Date of Birth _____

Current Address of Policyholder _____

City _____ State _____ ZIP _____ Telephone No. _____

Former Address of Policyholder _____

City _____ State _____ ZIP _____

Name of Employer _____

Associate/Agent Signature and Writing Number _____
Licensed Associate/Agent

PLEASE MAKE THE FOLLOWING CHANGES TO MY POLICY:

❑ **ADDITIONS ONLY – Complete applicable questions listed below. Dependent Children must be under age 25 at the time of application.**

Does anyone to be added currently have a Specified Health Event policy with Aflac? ❑ Yes ❑ No

If Yes, please complete the Supplemental Notification section at the end of this application and be aware that anyone to be added cannot have this policy without canceling their Specified Health Event policy with Aflac.

Does anyone to be added under the Lump Sum Cancer Benefit Rider or Lump Sum Cancer Policy have any other Cancer coverage with Aflac? ❑ Yes ❑ No ❑ N/A

If Yes, please complete the Supplemental Notification section at the end of this application and be aware that anyone to be added cannot have this policy without canceling their Cancer policy with Aflac.

Person(s) to be Added _____
Last Name First Name MI Title

Sex ❑Male ❑Female

Relationship ❑ Spouse ❑ Child

DOB of spouse or Dependent Child (other than a newborn) _____

Reason for Addition ❑ Marriage ❑ Birth ❑ Request

Date of Marriage/Birth/Request _____

New Coverage Desired ❑ One-Parent Family ❑ Two-Parent Family ❑ Named Insured/Spouse Only

PLEASE COMPLETE THE FOLLOWING QUESTIONS
FOR REINSTATEMENT OF OR ADDITIONS TO THE LUMP SUM CRITICAL ILLNESS POLICY

1. Has anyone to be covered used tobacco products or products containing nicotine of any type in the last 12 months? ❑ Yes ❑ No
   If yes, you are eligible to reinstate/apply for a maximum of $20,000 (4 units) of coverage. This information will be verified at the time of claim.

2. Has anyone to be covered been to see a member of the medical profession about a medical condition that has yet to be diagnosed? ❑ Yes ❑ No
   If yes, you are eligible to reinstate/apply for a maximum of $20,000 (4 units) of coverage.

If Question 1 or 2 is answered Yes, was it the:

❑ Policyholder ❑ Spouse ❑ Child

_____
Name of person(s)

You are eligible to reinstate/apply for a maximum of $20,000 (4 units) of coverage.

3. Does anyone to be covered have any condition for which any medical procedure (including but not limited to surgery, child delivery, organ or bone marrow transplant) has been planned or the possibility of which has been discussed with medical personnel? ❑ Yes ❑ No

4. Does anyone to be covered currently have or in the last 12 months, has anyone to be covered been diagnosed with or treated for any of the following conditions or had any of the following procedures: ❑ Yes ❑ No

Systemic lupus	irregular heart beat
pulmonary hypertension	chest pains
cystic fibrosis	vascular insufficiency (circulatory problems)
uncontrolled hypertension/high blood pressure	renal hypertension
tachycardia	diabetes (Type II) diagnosed prior to age 30

5. Within the last 5 years, has anyone to be covered been diagnosed with or treated for any of the following conditions or had any of the following procedures: ❑ Yes ❑ No

heart attack	pulmonary fibrosis
cardiomyopathy	diabetes and used tobacco after diagnosis
bypass/stents/angioplasty	diabetes treated with insulin
atrial fibrillation	diabetes with complications to include nephropathy
implant of pacemaker/defibrillator	neuropathy; or retinopathy
heart surgery (including valve replacement	kidney disease or disorder (not including stones)
or correction)	liver disease or disorder (excluding Hepatitis A)
congestive heart failure	the administration of chemotherapy
stroke/TIA	sarcoidosis
chronic obstructive pulmonary disease (COPD)	alcohol or drug abuse
emphysema	

If any one of Questions 3 – 5 is answered Yes, was it the:

❑ Policyholder ❑ Spouse ❑ Child

_____
Name of person(s)

Any person(s) indicated above will not be covered under this policy. If the Policyholder, the policy will not be reinstated; therefore, do not submit this application.

If a Child, are there other children to be covered? ❑Yes ❑ No

PLEASE COMPLETE THE FOLLOWING QUESTION
FOR REINSTATEMENT OF OR ADDITIONS FOR MORE THAN $20,000 (4 UNITS) OF COVERAGE.
Additional underwriting may be required.

6. During the last 6 months, have you received any medical treatment, including injections, or been prescribed or taken medications (other than prescription contraceptives)? ❑ Yes ❑ No
   If yes, please provide descriptive information below.

Medical Conditions/Treatments	Onset (mo/yr)	Surgery Performed? (If yes, provide the type of procedure and date)	Date Last Treated	Released by Physician	For Hypertension and Diabetes, List the Average Reading (for the last three months)
				❑Yes ❑No	
				❑Yes ❑No	
				❑Yes ❑No	
				❑Yes ❑No	
				❑Yes ❑No	
				❑Yes ❑No	

Medication Name	Dosage	Date First Prescribed	Medical Condition

PLEASE COMPLETE THE FOLLOWING QUESTIONS
FOR REINSTATEMENT OF OR ADDITIONS TO THE LUMP SUM CANCER BENEFIT RIDER

7. Has anyone to be covered been to see a member of the medical profession about a medical condition that has yet to be diagnosed? ❑ Yes ❑ No

8. Within the last 5 years, has anyone to be covered been diagnosed with or treated for any of the following conditions or had any of the following procedures: ❑ Yes ❑ No

   Internal cancer (including myelodysplastic blood disorder and myeloproliferative blood disorder)
   Melanoma (Clark's Level III or higher or a Breslow Level greater than 1.5 mm.)
   Carcinoma In Situ

If Question 7 or 8 is answered Yes, was it the:

❑ Policyholder ❑ Spouse ❑ Child

_____

Name of person(s)

Any person(s) indicated above will not be covered under this rider.
If the Policyholder, this rider will not be reinstated.

If a Child, are there other children to be covered? ❑Yes ❑ No

9. Has anyone to be covered had Internal Cancer that was diagnosed or last treated over five years ago? ❑ Yes ❑ No
If yes, you are eligible to reinstate/apply for a maximum of $20,000 (4 units) of coverage. This information will be verified at the time of claim.

If Question 9 is answered Yes, was it the:

❑ Policyholder ❑ Spouse ❑ Child

_____

Name of person(s)

You are eligible to reinstate/apply for a maximum of $20,000 (4 units) of coverage.

PLEASE COMPLETE THE FOLLOWING QUESTIONS
FOR REINSTATEMENT OF OR ADDITIONS TO THE LUMP SUM CANCER POLICY

1. Has anyone to be covered been to see a member of the medical profession about a medical condition that has yet to be diagnosed? ❑ Yes ❑ No

2. Within the last 5 years, has anyone to be covered been diagnosed with or treated for any of the following conditions or had any of the following procedures: ❑ Yes ❑ No

   Internal cancer (including myelodysplastic blood disorder and myeloproliferative blood disorder)
   Melanoma (Clark's Level III or higher or a Breslow Level greater than 1.5 mm.)
   Carcinoma In Situ

If Question 1 or 2 is answered Yes, was it the:

❑ Policyholder ❑ Spouse ❑ Child

_____

Name of person(s)

Any person(s) indicated above will not be covered under this policy. If the Policyholder, the policy will not be reinstated; therefore, do not submit this application.

If a Child, are there other children to be covered? ❑Yes ❑ No

3. Has anyone to be covered used tobacco products or products containing nicotine of any type in the last 12 months? ❑ Yes ❑ No
If yes, you are eligible to reinstate/apply for a maximum of $20,000 (4 units) of the Internal Cancer Benefit. This information will be verified at the time of claim.

4. Has anyone to be covered had Internal Cancer that was diagnosed or last treated over five years ago? ❑ Yes ❑ No
If yes, you are eligible to reinstate/apply for a maximum of $20,000 (4 units) of the Internal Cancer Benefit. This information will be verified at the time of claim.

If Question 3 or 4 is answered Yes, was it the:

❑ Policyholder ❑ Spouse ❑ Child

_____

Name of person(s)

You are eligible to reinstate/apply for a maximum of $20,000 (4 units) of the Internal Cancer Benefit.

SUPPLEMENTAL NOTIFICATION
COMPLETE IF YOU ARE REPLACING/TERMINATING EXISTING AFLAC SPECIFIED HEALTH EVENT COVERAGE.

I, _____ , am applying for Aflac's Lump Sum Critical Illness policy which contains Specified Health Event benefits. I currently have benefits under Aflac's Specified Health Event policy number _____. I understand that I must cancel my existing Aflac Specified Health Event policy to purchase this policy.

❑ Please cancel my Aflac Specified Health Event policy number _____ so that this Lump Sum Critical Illness policy can be issued. **I understand that I will be terminating benefits provided for in my Specified Health Event policy that may not be provided for in the new Lump Sum Critical Illness policy.**

SUPPLEMENTAL NOTIFICATION
COMPLETE IF YOU ARE REPLACING/TERMINATING EXISTING AFLAC CANCER COVERAGE.

I, _____, am applying for Aflac's Lump Sum Critical Illness Policy with a Lump Sum Cancer Benefit Rider or Aflac's Lump Sum Cancer Policy which contains cancer benefits. I currently have cancer benefits under Aflac's Cancer Policy Number _____. I understand that I must cancel my existing Aflac Cancer policy to purchase this policy.

❑ Please cancel my Aflac Cancer policy number _____ so that this Lump Sum Critical Illness policy with a Lump Sum Cancer Benefit Rider or Lump Sum Cancer Policy can be issued. **I understand that I will be terminating benefits provided for in my Cancer policy that may not be provided for in the new Lump Sum Critical Illness policy with a Lump Sum Cancer Benefit Rider or Lump Sum Cancer Policy.**

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus (Aflac) or any person or entity acting on its part: any medical professional, medical care institution, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), MIB, Inc., formerly known as the Medical Information Bureau, consumer reporting agency, or employer.

"Information" means facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, driving record, or any other medical or nonmedical facts that Aflac deems appropriate to determine eligibility for insurance or to evaluate a claim for benefits during the time this authorization is valid. I also authorize Aflac to give information to MIB, Inc.

I understand that any disclosure of health information to Aflac for the purpose of determining eligibility for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be redisclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Aflac for enrollment or to determine eligibility for insurance or for underwriting or risk rating (where applicable) purposes and, should coverage be issued, the information may be used to contest a claim for benefits or the issuance of the policy itself during the contestability period provided in the policy.

I understand that Aflac is conditioning the issuance of coverage on the provision of this authorization, and that, while I may refuse to sign this authorization, my refusal to do so could result in coverage not being issued.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac has taken action in reliance on this authorization or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac, [Attn: Policy Service, 1932 Wynnton Road, Columbus, GA 31999].

Unless otherwise revoked, I agree that this authorization will expire on the earlier of the date Aflac notifies me of its declination of my application for coverage or, if a policy is issued, two years from the policy effective date.

I agree that a copy of this authorization is as valid as the original.

I, the undersigned Policyholder, agree that by signing below I am submitting an application to Aflac for the reinstatement of my policy. The reinstated policy will cover only loss resulting from a condition that begins on or after the date of reinstatement.

I have read, or had read to me, the completed application and realize policy reinstatement is based upon statements and answers provided herein, and they are complete and true. I understand, for the purposes of the Time Limit on Certain Defenses provision of the policy, that the Effective Date of the policy shall now be the reinstatement date. I also understand that Aflac and I will have the same rights as provided under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed on or attached to the policy in connection with the reinstatement. I further understand that coverage under the reinstated policy is subject to the terms set forth in my policy Reinstatement Provision. No person to be insured is covered by any Title XIX programs such as Medicaid.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature (X) _____

Signed and Dated at _____ on _____
City and State Date

If we at Aflac fail to provide you with reasonable and adequate service, you should feel free to contact:
ARKANSAS INSURANCE DEPARTMENT - CONSUMER SERVICES DIVISION
1200 WEST THIRD STREET
LITTLE ROCK, ARKANSAS 72201-1904
Telephone (501) 371-2640 or Toll-Free 1-800-852-5494

MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.
[FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).
VISIT OUR WEB SITE AT AFLAC.COM.]

REQUEST FOR ADDITIONS/APPLICATION FOR REINSTATEMENT
LUMP SUM CRITICAL ILLNESS INSURANCE FOR A72100 SERIES
LUMP SUM CANCER INSURANCE FOR A72200 SERIES
American Family Life Assurance Company of Columbus (Aflac)
[Worldwide Headquarters: Columbus, GA 31999
For information, call toll-free 1-800-99-AFLAC (1-800-992-3522)]

Name of Policyholder _____ SSN _____ (Optional)

Policy Number _____ Date of Birth _____

Current Address of Policyholder _____

City _____ State _____ ZIP _____ Telephone No. _____

Former Address of Policyholder _____

City _____ State _____ ZIP _____

Name of Employer _____

Associate/Agent Signature and Writing Number _____
Licensed Associate/Agent

PLEASE MAKE THE FOLLOWING CHANGES TO MY POLICY:

❑ **ADDITIONS ONLY – Complete applicable questions listed below. Dependent Children must be under age 25 at the time of application.**

Does anyone to be added currently have a Specified Health Event policy with Aflac? ❑ Yes ❑ No

If Yes, please complete the Supplemental Notification section at the end of this application and be aware that anyone to be added cannot have this policy without canceling their Specified Health Event policy with Aflac.

Does anyone to be added under the Lump Sum Cancer Benefit Rider or Lump Sum Cancer Policy have any other Cancer coverage with Aflac? ❑ Yes ❑ No ❑ N/A

If Yes, please complete the Supplemental Notification section at the end of this application and be aware that anyone to be added cannot have this policy without canceling their Cancer policy with Aflac.

Person(s) to be Added _____
Last Name First Name MI Title

Sex ❑Male ❑Female

Relationship ❑ Spouse ❑ Child

DOB of spouse or Dependent Child (other than a newborn)_____

Reason for Addition ❑ Marriage ❑ Birth ❑ Request

Date of Marriage/Birth/Request _____

New Coverage Desired ❑ One-Parent Family ❑ Two-Parent Family ❑ Named Insured/Spouse Only

PLEASE COMPLETE THE FOLLOWING QUESTION
FOR REINSTATEMENT OF OR ADDITIONS TO THE LUMP SUM CRITICAL ILLNESS POLICY

1. Within the last 24 months, (excluding routine childbirth), has anyone to be covered been (a) out of work due to sickness or injury more than 5 consecutive days; (b) in a hospital or emergency room (ER) for more than 24 hours for sickness; (c) diagnosed or treated for hypertension or diabetes; or is anyone to be covered currently disabled due to sickness or injury? ❑ Yes ❑ No

PLEASE COMPLETE THE FOLLOWING QUESTIONS IF QUESTION 1 IS ANSWERED YES OR YOU ARE REINSTATING OR APPLYING FOR MORE THAN $20,000 (4 UNITS) OF COVERAGE.

2. Does anyone to be covered have any condition for which any medical procedure (including but not limited to surgery, child delivery, organ or bone marrow transplant) has been planned or the possibility of which has been discussed with medical personnel? ❑ Yes ❑ No

3. Does anyone to be covered currently have or in the last 12 months, has anyone to be covered been diagnosed with or treated for any of the following conditions or had any of the following procedures: ❑ Yes ❑ No

Systemic lupus
pulmonary hypertension
cystic fibrosis
uncontrolled hypertension/high blood pressure
tachycardia
irregular heart beat
chest pains
vascular insufficiency (circulatory problems)
renal hypertension
diabetes (Type II) diagnosed prior to age 30

4. Within the last 5 years, has anyone to be covered been diagnosed with or treated for any of the following conditions or had any of the following procedures: ❑ Yes ❑ No

heart attack
cardiomyopathy
bypass/stents/angioplasty
atrial fibrillation
implant of pacemaker/defibrillator
heart surgery (including valve replacement or correction)
congestive heart failure
stroke/TIA
chronic obstructive pulmonary disease (COPD)
emphysema
pulmonary fibrosis
diabetes and used tobacco after diagnosis
diabetes treated with insulin
diabetes with complications to include nephropathy; neuropathy; or retinopathy
kidney disease or disorder (not including stones)
liver disease or disorder (excluding Hepatitis A)
the administration of chemotherapy
sarcoidosis
alcohol or drug abuse

If any one of Questions 2 – 4 is answered Yes, was it the:

❑ Policyholder ❑ Spouse ❑ Child

_____
Name of person(s)

If spouse or child is indicated above, he/she will not be covered under the policy. If the Policyholder, the policy will not be reinstated; therefore, do not submit this application.

If a Child, are there other children to be covered? ❑Yes ❑ No

PLEASE COMPLETE THE FOLLOWING QUESTION
FOR REINSTATEMENT OF OR ADDITIONS FOR MORE THAN $20,000 (4 UNITS) OF COVERAGE.
Additional underwriting may be required.

5. During the last 6 months, have you received any medical treatment, including injections, or been prescribed or taken medications (other than prescription contraceptives)? ❑ Yes ❑ No
If yes, please provide descriptive information below.

Medical Conditions/Treatments	Onset (mo/yr)	Surgery Performed? (If yes, provide the type of procedure and date)	Date Last Treated	Released by Physician	For Hypertension and Diabetes, List the Average Reading (for the last three months)
				❑Yes ❑No	
				❑Yes ❑No	
				❑Yes ❑No	
				❑Yes ❑No	
				❑Yes ❑No	
				❑Yes ❑No	

Medication Name	Dosage	Date First Prescribed	Medical Condition

PLEASE COMPLETE THE FOLLOWING QUESTIONS
FOR REINSTATEMENT OF OR ADDITIONS TO THE LUMP SUM CANCER BENEFIT RIDER

6. Has anyone to be covered been to see a member of the medical profession about a medical condition that has yet to be diagnosed? ❑ Yes ❑ No

7. Within the last 5 years, has anyone to be covered been diagnosed with or treated for any of the following conditions or had any of the following procedures: ❑ Yes ❑ No

   Internal cancer (including myelodysplastic blood disorder and myeloproliferative blood disorder)
   Melanoma (Clark's Level III or higher or a Breslow Level greater than 1.5 mm.)
   Carcinoma In Situ

If Question 6 or 7 is answered Yes, was it the:

❑ Policyholder ❑ Spouse ❑ Child

_____
Name of person(s)

Any person(s) indicated above will not be covered under this rider.
If the Policyholder, this rider will not be reinstated.

If a Child, are there other children to be covered? ❑Yes ❑ No

8. Has anyone to be covered had Internal Cancer that was diagnosed or last treated over five years ago? ❑ Yes ❑ No
   If yes, you are eligible to reinstate/apply for a maximum of $20,000 (4 units) of coverage. This information will be verified at the time of claim.

If Question 8 is answered Yes, was it the:

❑ Policyholder ❑ Spouse ❑ Child

_____
Name of person(s)

You are eligible to reinstate/apply for a maximum of $20,000 (4 units) of coverage.

PLEASE COMPLETE THE FOLLOWING QUESTIONS
FOR REINSTATEMENT OF OR ADDITIONS TO THE LUMP SUM CANCER POLICY

1. Has anyone to be covered been to see a member of the medical profession about a medical condition that has yet to be diagnosed? ❑ Yes ❑ No

2. Within the last 5 years, has anyone to be covered been diagnosed with or treated for any of the following conditions or had any of the following procedures: ❑ Yes ❑ No

   Internal cancer (including myelodysplastic blood disorder and myeloproliferative blood disorder)
   Melanoma (Clark's Level III or higher or a Breslow Level greater than 1.5 mm.)
   Carcinoma In Situ

If Question 1 or 2 is answered Yes, was it the:

❑ Policyholder ❑ Spouse ❑ Child

_____
Name of person(s)

Any person(s) indicated above will not be covered under this policy. If the Policyholder, the policy will not be reinstated; therefore, do not submit this application.

If a Child, are there other children to be covered? ❑Yes ❑ No

3. Has anyone to be covered had Internal Cancer that was diagnosed or last treated over five years ago? ❑ Yes ❑ No
   If yes, you are eligible to reinstate/apply for a maximum of $20,000 (4 units) of the Internal Cancer Benefit. This information will be verified at time of claim.

If Question 3 is answered Yes, was it the:

❑ Policyholder ❑ Spouse ❑ Child

_____
Name of person(s)

You are eligible to reinstate/apply for a maximum of $20,000 (4 units) of the Internal Cancer Benefit.

SUPPLEMENTAL NOTIFICATION
COMPLETE IF YOU ARE REPLACING/TERMINATING EXISTING AFLAC SPECIFIED HEALTH EVENT COVERAGE.

I, _____ , am applying for Aflac's Lump Sum Critical Illness policy which contains Specified Health Event benefits. I currently have benefits under Aflac's Specified Health Event policy number _____. I understand that I must cancel my existing Aflac Specified Health Event policy to purchase this policy.

❑ Please cancel my Aflac Specified Health Event policy number _____ so that this Lump Sum Critical Illness policy can be issued. **I understand that I will be terminating benefits provided for in my Specified Health Event policy that may not be provided for in the new Lump Sum Critical Illness policy.**

SUPPLEMENTAL NOTIFICATION
COMPLETE IF YOU ARE REPLACING/TERMINATING EXISTING AFLAC CANCER COVERAGE.

I, _____, am applying for Aflac's Lump Sum Critical Illness Policy with a Lump Sum Cancer Benefit Rider or Aflac's Lump Sum Cancer Policy which contains cancer benefits. I currently have cancer benefits under Aflac's Cancer Policy Number _____. I understand that I must cancel my existing Aflac Cancer policy to purchase this policy.

❑ Please cancel my Aflac Cancer policy number _____ so that this Lump Sum Critical Illness policy with a Lump Sum Cancer Benefit Rider or Lump Sum Cancer Policy can be issued. **I understand that I will be terminating benefits provided for in my Cancer policy that may not be provided for in the new Lump Sum Critical Illness policy with a Lump Sum Cancer Benefit Rider or Lump Sum Cancer Policy.**

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus (Aflac) or any person or entity acting on its part: any medical professional, medical care institution, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), MIB, Inc., formerly known as the Medical Information Bureau, consumer reporting agency, or employer.

"Information" means facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, driving record, or any other medical or nonmedical facts that Aflac deems appropriate to determine eligibility for insurance or to evaluate a claim for benefits during the time this authorization is valid. I also authorize Aflac to give information to MIB, Inc.

I understand that any disclosure of health information to Aflac for the purpose of determining eligibility for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be redisclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Aflac for enrollment or to determine eligibility for insurance or for underwriting or risk rating (where applicable) purposes and, should coverage be issued, the information may be used to contest a claim for benefits or the issuance of the policy itself during the contestability period provided in the policy.

I understand that Aflac is conditioning the issuance of coverage on the provision of this authorization, and that, while I may refuse to sign this authorization, my refusal to do so could result in coverage not being issued.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac has taken action in reliance on this authorization or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac, [Attn: Policy Service, 1932 Wynnton Road, Columbus, GA 31999].

Unless otherwise revoked, I agree that this authorization will expire on the earlier of the date Aflac notifies me of its declination of my application for coverage or, if a policy is issued, two years from the policy effective date.

I agree that a copy of this authorization is as valid as the original.

I, the undersigned Policyholder, agree that by signing below I am submitting an application to Aflac for the reinstatement of my policy. The reinstated policy will cover only loss resulting from a condition that begins on or after the date of reinstatement.

I have read, or had read to me, the completed application and realize policy reinstatement is based upon statements and answers provided herein, and they are complete and true. I understand, for the purposes of the Time Limit on Certain Defenses provision of the policy, that the Effective Date of the policy shall now be the reinstatement date. I also understand that Aflac and I will have the same rights as provided under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed on or attached to the policy in connection with the reinstatement. I further understand that coverage under the reinstated policy is subject to the terms set forth in my policy Reinstatement Provision. No person to be insured is covered by any Title XIX programs such as Medicaid.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature (X) _____

Signed and Dated at _____ on _____
City and State Date

If we at Aflac fail to provide you with reasonable and adequate service, you should feel free to contact:

ARKANSAS INSURANCE DEPARTMENT - CONSUMER SERVICES DIVISION
1200 WEST THIRD STREET
LITTLE ROCK, ARKANSAS 72201-1904
Telephone (501) 371-2640 or Toll-Free 1-800-852-5494

MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.
[FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).
VISIT OUR WEB SITE AT AFLAC.COM.]

American Family Life Assurance Company of Columbus (Aflac)
[Worldwide Headquarters: Columbus, Georgia 31999]

I, the undersigned Proposed Insured/Employee, agree that by signing below I am submitting an application to Aflac for the following insurance policy(ies).

- ❑ Lump Sum Critical Illness
- ❑ Lump Sum Cancer
- ❑ Short Term Disability
- ❑ Accident
- ❑ Dental
- ❑ Hospital Confinement
- ❑ Specified Health Event
- ❑ Vision
- ❑ Specified Disease/Cancer
- ❑ Hospital Intensive Care

- This is an electronic application. It has been completed and signed by me electronically without the presence of an associate/agent.
- I verify that the unique identifier used to sign this application is mine and that by clicking the "Accept" button I am signing the application(s) electronically. I further understand, agree, and authorize my employer to deduct the premiums for this policy(ies) from my paycheck.
- I would prefer to receive an electronic copy of my policy(ies) instead of paper. ❑ Yes ❑ No

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed and Dated at _____ on _____
City and State Date

Proposed Insured's/Employee's Signature _____

Writing Associate/Agent: Please complete the following – it will become part of the policy.
AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC),
CLIENT SERVICES AND ADMINISTRATION,
[WORLDWIDE HEADQUARTERS • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999.]

If we at Aflac fail to provide you with reasonable and adequate service, you should feel free to contact:
ARKANSAS INSURANCE DEPARTMENT – CONSUMER SERVICES DIVISION
1200 WEST THIRD STREET, LITTLE ROCK, ARKANSAS, 72201-1904, TELEPHONE (501) 371-2640 OR TOLL-FREE 1-800-852-5494.

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- ❑ Accident
- ❑ Dental
- ❑ Hospital Confinement
- ❑ Specified Health Event
- ❑ Vision
- ❑ Specified Disease/Cancer
- ❑ Hospital Intensive Care

I would prefer to receive an electronic copy of my policy(ies) instead of paper. ❑ Yes ❑ No

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed and Dated at _____ on _____
City and State Date

Proposed Insured's/Employee's Signature _____

I certify that I personally saw the Proposed Insured/Employee when the application was written, and each question was asked of the Proposed Insured/Employee and answered as recorded. All answers above are correct to the best of my knowledge.

Associate's/Agent's Signature _____ Date _____
Licensed Resident Associate/Agent

Writing Associate/Agent: Please complete the following – it will become part of the policy.
AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC),
CLIENT SERVICES AND ADMINISTRATION,
[WORLDWIDE HEADQUARTERS • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999.]

Associate/Agent's Name _____

Associate/Agent's Address _____ Telephone _____

If we at Aflac fail to provide you with reasonable and adequate service, you should feel free to contact:
ARKANSAS INSURANCE DEPARTMENT – CONSUMER SERVICES DIVISION
1200 WEST THIRD STREET, LITTLE ROCK, ARKANSAS, 72201-1904, TELEPHONE (501) 371-2640 OR TOLL-FREE 1-800-852-5494.

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AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)

[Worldwide Headquarters: 1932 WYNNTON ROAD, COLUMBUS, GEORGIA 31999
TOLL-FREE 1-800-99-AFLAC (1-800-992-3522)]

The policy described in this Outline of Coverage provides supplemental coverage and will be issued only to supplement insurance already in force.

LIMITED BENEFIT, LUMP SUM CRITICAL ILLNESS INSURANCE
Outline of Coverage for Policy Form Series A72100
THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.

If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide furnished by Aflac.

(1) Read Your Policy Carefully: This Outline of Coverage provides a very brief description of some of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and Aflac. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

(2) Lump Sum Critical Illness Insurance Coverage is designed to supplement your existing accident and sickness coverage only when certain losses occur as a result of Critical Illness Events. Critical Illness Events are: Heart Attack, Stroke, Major Human Organ Transplant, End-Stage Renal Failure, Paralysis, or Coma. Coverage is provided for the benefits outlined in Part (3). The benefits described in Part (3) may be limited by Part (5).

(3) Benefits: Subject to the Pre-existing Condition Limitations, Limitations and Exclusions, and all other policy provisions, we will pay the following benefits for a covered Critical Illness Event that occurs while coverage is in force.

For any benefit to be payable, the Onset Date of the Loss must occur on or after the Effective Date of coverage and while coverage is in force. If more than one Loss per Covered Person occurs on the same day, only the highest eligible benefit will be paid. Aflac will not accept an assignment of these benefits. All benefits will be payable to you. Any accrued benefits unpaid at your death will be paid to your estate.

A. MAJOR CRITICAL ILLNESS EVENT BENEFIT: Aflac will pay [$ _____] upon a Covered Person's Onset Date of any of the following Critical Illness Events:

1) Heart Attack
2) Stroke
3) End-Stage Renal Failure
4) Coma
5) Paralysis
6) Major Human Organ Transplant

After qualifying for this benefit, such Covered Person will again become eligible for this benefit after five years from the later of (1) the Onset Date of any Critical Illness Event of such Covered Person or (2) the latest hospitalization or surgery due to such Covered Person's Critical Illness Event. No lifetime maximum.

B. SUBSEQUENT CRITICAL ILLNESS EVENT BENEFIT: After a Covered Person has previously qualified for benefits under Benefit A above, Aflac will pay $5,000 upon that Covered Person's Onset Date of:

1) a **recurrence** of that **same** Critical Illness Event or
2) an occurrence of a **different** Critical Illness Event.

For this benefit to be payable, the Onset Date of the Critical Illness Event must be 180 days or more from the Onset Date of any previously paid Critical Illness Event for such Covered Person. This benefit is not payable on the same day as the Major Critical Illness Event Benefit. No lifetime maximum.

C. CORONARY ARTERY BYPASS GRAFT SURGERY BENEFIT: Aflac will pay $3,000 when a Covered Person undergoes Coronary Artery Bypass Graft Surgery. This benefit is payable once per Covered Person, per lifetime.

(4) Optional Benefits:

LUMP SUM CANCER BENEFIT RIDER: (Series A72050) Applied for ❑ Yes ❑ No

This rider is issued on the basis that the information shown on the application is correct and complete. If any answers on your application for this rider are incorrect or incomplete, the benefits under this rider will be the lesser of the benefits that you would have been eligible to purchase if a correct or complete answer had been given or your original rider benefit amount. Any overpayment of premium will be refunded to you, less any claims paid.

While this coverage is in force, we will pay the following benefits, as applicable, subject to the Pre-existing Condition Limitations, Limitations and Exclusions, and all other policy provisions unless modified herein.

For benefits to be payable, the Onset Date of the Loss must occur on or after the Effective Date of coverage, while coverage is in force, and must be separated by 180 days or more from the Onset Date of any other covered Loss. If more than one Loss per Covered Person occurs within 180 days, only the highest eligible benefit will be paid. Aflac will not accept an assignment of these benefits. All benefits will be payable to you. Any accrued benefits unpaid at your death will be paid to your estate.

A. INTERNAL CANCER BENEFIT: Aflac will pay [$_____] upon a Covered Person's Onset Date of Internal Cancer. This benefit is payable once per Covered Person, per lifetime.

B. CARCINOMA IN SITU BENEFIT: Aflac will pay $2,000 upon a Covered Person's Onset Date of Carcinoma In Situ. This benefit is payable once per Covered Person, per lifetime.

C. CANCER-RELATED DEATH BENEFIT: Aflac will pay $5,000 when a Covered Person suffers a Cancer-Related Death.

Exceptions, Reductions and Limitations of Rider A72050 Series:

A. Benefits are not provided for premalignant conditions or conditions with malignant potential (unless specifically covered); complications of cancer; or any other disease, sickness, or incapacity. Aflac will not pay benefits for recurrence, direct extension, or metastatic spread of any cancer diagnosed prior to the Effective Date of coverage.

B. Aflac will not pay benefits for any Loss that is caused by a Pre-existing Condition unless the Onset Date is more than 12 months after the Effective Date of coverage. Benefits are payable for only one covered Loss at a time per Covered Person.

C. Aflac will not pay benefits for a Loss that is diagnosed outside the territorial limits of the United States, its possessions, or the countries of Canada and Mexico.

D. Aflac will not pay benefits whenever coverage provided by this rider is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

E. For benefits to be payable, the Onset Date must occur on or after the Effective Date of coverage, while coverage is in force and must be separated by 180 days or more from the Onset Date of any other covered Loss. If more than one Loss per Covered Person occurs within 180 days, only the highest eligible benefit will be paid.

F. Aflac will not pay benefits for Skin Cancers.

RETURN OF PREMIUM BENEFIT: (Series A72051) Applied for ❑ Yes ❑ No

Aflac will pay you a cash value based upon the annualized premium paid for this rider, the policy, and any other attached benefit riders **(premium paid for the policy and other attached benefit riders will be calculated at the original premium in effect on the rider Effective Date and will not include premium increases that may occur for the policy or other such riders)**. All Return of Premium Benefits/cash values paid will be less any claims paid. If you surrender this rider for its cash value after the Onset Date of a Loss but before claims are submitted, we will reduce subsequent claim payment(s) by the amount of the cash value paid. Both the policy and the rider must remain in force for 20 consecutive years for you to obtain a maximum refund of premiums paid.

The cash value for premium paid for the policy and rider begins on the fifth rider anniversary date.

Your cash value is based upon annualized premium of **xxxxxxx**. If you surrender this rider after its fifth anniversary and such surrender occurs between rider anniversaries, a prorated amount for the partial year will be paid. The proration will be calculated by taking the cash value difference between the last and next anniversary dates, dividing by 12, and multiplying by the number of months that premiums were earned in the partial year at the time of surrender. This proration will then be added to the cash value on the last rider anniversary date, and this will be the cash value paid.

IMPORTANT! READ CAREFULLY: This rider will terminate on the earlier of: its 20th anniversary date and payment of the cash value; your surrender of it for its cash value between the fifth and 20th anniversary dates; your death prior to its 20th anniversary date, in which case the cash value (if any) will be paid to your estate; your failure to pay the premium for this rider, in which case any cash values due will be paid; the policy's termination, in which case any cash values due will be paid; or the time that claims paid equal or exceed the cash value that would be paid on the 20th policy anniversary. When this rider terminates (is no longer in force), no further premium will be charged for it.

SUDDEN CARDIAC DEATH BENEFIT RIDER: (Series A72052) Applied for ❑ Yes ❑ No

While this coverage is in force, we will pay the following benefit, as applicable, subject to the Pre-existing Condition Limitations, Limitations and Exclusions, and all other policy provisions unless modified herein.

For benefits to be payable, the Onset Date must occur on or after the Effective Date of coverage, while coverage is in force, and must be separated by 180 days or more from the Onset Date of any previously paid Critical Illness Event for such Covered Person. If Sudden Cardiac Death occurs within 180 days of a Critical Illness Event for the same Covered Person, only the highest eligible benefit will be paid. If Coronary Artery Bypass Graft Surgery and Sudden Cardiac Death occur on the same day, only the highest eligible benefit will be paid. Aflac will not accept an assignment of these benefits. All benefits will be payable to you or your estate.

A. SUDDEN CARDIAC DEATH BENEFIT: Aflac will pay [$_____] upon a Covered Person's Onset Date of Sudden Cardiac Death. This benefit is payable once per Covered Person, per lifetime.

(5) Exceptions, Reductions and Limitations of the Policy (This is not a daily hospital expense plan.):

A. Aflac will not pay benefits for any Loss that is caused by a Pre-existing Condition unless it begins more than 12 months after the Effective Date of coverage. Benefits are payable for only one covered Loss at a time per Covered Person.

B. Aflac will not pay benefits for any event that is diagnosed or treated outside the territorial limits of the United States, its possessions, or the countries of Canada and Mexico.

C. Aflac will not pay benefits whenever coverage provided by this policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

D. For any benefit to be payable, the Onset Date of the Loss must occur on or after the Effective Date of coverage and while coverage is in force. If more than one Loss per Covered Person occurs on the same day, only the highest eligible benefit will be paid.

E. This policy does not cover Loss caused by or resulting from:

1. Using any drug, narcotic, hallucinogen, or chemical substance (unless administered by a Physician and taken according to the Physician's instructions) or voluntarily taking any kind of poison or inhaling any kind of gas or fumes;
2. Participating in, or attempting to participate in, an illegal activity that is defined as a felony, whether charged or not ("felony" is as defined by the law of the jurisdiction in which the activity takes place); or being incarcerated in any type penal institution;
3. Intentionally self-inflicting a bodily injury or committing or attempting suicide, while sane or insane;
4. Being exposed to war or any act of war, declared or undeclared;
5. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve.

A Pre-existing Condition is an illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Benefits for a Loss that is caused by a Pre-existing Condition will not be covered unless the Onset Date is more than 12 months after the Effective Date of coverage.

(6) Renewability: The policy is guaranteed-renewable for your lifetime by payment of the premium in effect at the beginning of each renewal period. Premium rates may change only if changed on all policies of the same form number and class in force in your state.

RETAIN FOR YOUR RECORDS.
THIS OUTLINE OF COVERAGE IS ONLY A BRIEF SUMMARY OF THE COVERAGE PROVIDED.
THE POLICY ITSELF SHOULD BE CONSULTED TO DETERMINE
GOVERNING CONTRACTUAL PROVISIONS.

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)

[Worldwide Headquarters: 1932 WYNNTON ROAD, COLUMBUS, GEORGIA 31999
TOLL-FREE 1-800-99-AFLAC (1-800-992-3522)]

The policy described in this Outline of Coverage provides supplemental coverage and will be issued only to supplement insurance already in force.

LIMITED BENEFIT, LUMP SUM CANCER INSURANCE
Outline of Coverage for Policy Form Series A72200
THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.

If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide furnished by Aflac.

(1) Read Your Policy Carefully: This Outline of Coverage provides a very brief description of some of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and Aflac. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

(2) Lump Sum Cancer Insurance Coverage is designed to supplement your existing accident and sickness coverage only when certain losses occur as a result of cancer. Coverage is provided for the benefits outlined in Part (3). The benefits described in Part (3) may be limited by Part (5).

(3) Benefits: Subject to the Pre-existing Condition Limitations, Limitations and Exclusions, and all other policy provisions, we will pay the following benefits for a covered cancer that occurs while coverage is in force.

For benefits to be payable, the Onset Date of the Loss must occur on or after the Effective Date of coverage, while coverage is in force, and must be separated by 180 days or more from the Onset Date of any other covered Loss for such Covered Person. If more than one Loss per Covered Person occurs within 180 days, only the highest eligible benefit will be paid. Aflac will not accept an assignment of these benefits. All benefits will be payable to you. Any accrued benefits unpaid at your death will be paid to your estate.

A. INTERNAL CANCER BENEFIT: Aflac will pay [$_____] upon a Covered Person's Onset Date of Internal Cancer. This benefit is payable once per Covered Person, per lifetime.

B. CARCINOMA IN SITU BENEFIT: Aflac will pay $2,000 upon a Covered Person's Onset Date of Carcinoma In Situ. This benefit is payable once per Covered Person, per lifetime.

C. CANCER-RELATED DEATH BENEFIT: Aflac will pay $5,000 when a Covered Person suffers a Cancer-Related Death.

(4) Optional Benefits:

RETURN OF PREMIUM BENEFIT: (Series A72051) Applied for ❑ Yes ❑ No

Aflac will pay you a cash value based upon the annualized premium paid for this rider, the policy, and any other attached benefit riders **(premium paid for the policy and other attached benefit riders will be calculated at the original premium in effect on the rider Effective Date and will not include premium increases that may occur for the policy or other such riders)**. All Return of Premium Benefits/cash values paid will be less any claims paid. If you surrender this rider for its cash value after the Onset Date of a Loss but before

claims are submitted, we will reduce subsequent claim payment(s) by the amount of the cash value paid. Both the policy and the rider must remain in force for 20 consecutive years for you to obtain a maximum refund of premiums paid.

The cash value for premium paid for the policy and rider begins on the fifth rider anniversary date.

Your cash value is based upon annualized premium of **xxxxxxx**. If you surrender this rider after its fifth anniversary and such surrender occurs between rider anniversaries, a prorated amount for the partial year will be paid. The proration will be calculated by taking the cash value difference between the last and next anniversary dates, dividing by 12, and multiplying by the number of months that premiums were earned in the partial year at the time of surrender. This proration will then be added to the cash value on the last rider anniversary date, and this will be the cash value paid.

IMPORTANT! READ CAREFULLY: This rider will terminate on the earlier of: its 20th anniversary date and payment of the cash value; your surrender of it for its cash value between the fifth and 20th anniversary dates; your death prior to its 20th anniversary date, in which case the cash value (if any) will be paid to your estate; your failure to pay the premium for this rider, in which case any cash values due will be paid; the policy's termination, in which case any cash values due will be paid; or the time that claims paid equal or exceed the cash value that would be paid on the 20th policy anniversary. When this rider terminates (is no longer in force), no further premium will be charged for it.

(5) Exceptions, Reductions and Limitations of the Policy (This is not a daily hospital expense plan.):

A. Benefits are not provided for premalignant conditions or conditions with malignant potential (unless specifically covered); complications of cancer; or any other disease, sickness, or incapacity. Aflac will not pay benefits for recurrence, direct extension, or metastatic spread of any cancer diagnosed prior to the Effective Date of coverage.

B. Aflac will not pay benefits for any Loss that is caused by a Pre-existing Condition unless the Onset Date is more than 12 months after the Effective Date of coverage. Benefits are payable for only one covered Loss at a time per Covered Person.

C. Aflac will not pay benefits for a Loss that is diagnosed outside the territorial limits of the United States, its possessions, or the countries of Canada and Mexico.

D. Aflac will not pay benefits whenever coverage provided by this policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

E. For benefits to be payable, the Onset Date must occur on or after the Effective Date of coverage, while coverage is in force and must be separated by 180 days or more from the Onset Date of any other covered Loss. If more than one Loss per Covered Person occurs within 180 days, only the highest eligible benefit will be paid.

F. Aflac will not pay benefits for Skin Cancers.

A Pre-existing Condition is an illness, disease, infection, or disorder for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Benefits for a Loss that is caused by a Pre-

existing Condition will not be covered unless the Onset Date is more than 12 months after the Effective Date of coverage.

(6) Renewability: The policy is guaranteed-renewable for your lifetime by payment of the premium in effect at the beginning of each renewal period. Premium rates may change only if changed on all policies of the same form number and class in force in your state.

RETAIN FOR YOUR RECORDS.
THIS OUTLINE OF COVERAGE IS ONLY A BRIEF SUMMARY OF THE COVERAGE PROVIDED.
THE POLICY ITSELF SHOULD BE CONSULTED TO DETERMINE
GOVERNING CONTRACTUAL PROVISIONS.

SERFF Tracking Number:	*AFLA-125856287*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*40777*
Company Tracking Number:	*A72000*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Lump Sum Critical Illness*		
Project Name/Number:	*Lump Sum Critical Illness & Lump Sum Cancer/*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AFLA-125856287*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*40777*
Company Tracking Number:	*A72000*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Lump Sum Critical Illness*		
Project Name/Number:	*Lump Sum Critical Illness & Lump Sum Cancer/*		

Supporting Document Schedules

Satisfied -Name: Certification/Notice **Review Status:** Approved-Closed 02/02/2009

Comments:

The filing letter includes Rule & Regulation 19, Rule & Regulation 49, and the required Flesch Certification along with the required officer signature.

Page three: Rule & Regulation 19, Rule & Regulation 49, and the required Flesch Certification
Page four: officer signature

Attachment:

72000 AR filingletter.pdf

Bypassed -Name: Application **Review Status:** Approved-Closed 02/02/2009

Bypass Reason: All applications are attached under the Form Schedule tab.

Comments:

Satisfied -Name: Outline of Coverage **Review Status:** Approved-Closed 02/02/2009

Comments:

Outline of Coverage forms attached below.

Attachments:

A72125AR.pdf
A72225AR.pdf

Satisfied -Name: Filing Fee Certification **Review Status:** Approved-Closed 02/02/2009

Comments:

The filing fee certification is attached below.

Attachment:

72000 AR FEECERT.pdf

Deborah T. Grantham
AIRC, HIA, ACS
Second Vice President
Compliance Department

November 5, 2008

Mr. Joe Musgrove
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

NAIC# 60380

RE: Lump Sum Critical Illness Policy Form A72100AR, Lump Sum Cancer Benefit Rider Form A72050, Return of Premium Benefit Rider Form A72051, and Sudden Cardiac Death Benefit Rider Form A72052, Application Forms A72PAPPAR, A72GAPPAR, and A72UAPPAR, Underwriting Application Forms LSCI and LSCIG, Signature Forms AsignAR and AsigncAR, Request for Additions/Application for Reinstatement Forms A72003AR and A72003GAR, Outline of Coverage Form A72125.

Lump Sum Cancer Policy Form A72200AR, Application Forms A72PCAPPAR, A72GCAPPAR, and A72UCAPPAR, Underwriting Application Forms LSCA and LSCAG, Outline of Coverage Form A72225.

Dear Mr. Musgrove:

Referenced forms are submitted for your review and approval. Nebraska, our state of domicile, has approved similar versions of these forms on October 3, 2008.

Lump Sum Critical Illness Policy Form A72100AR provides benefits for major critical illness events. Eligible critical illness events include Heart Attack, Stroke, End-Stage Renal Failure, Coma, Paralysis, and Major Human Organ Transplant occurring after the Effective Date of coverage. The Major Critical Illness Event Benefit may become payable again if the insured is free of any critical illness event, hospitalization or surgery due to a critical illness event for five years.

The Subsequent Critical Illness Event benefit will be paid at $5,000 for each covered person. These events must be separated by 180 days. The policy also provides a Coronary Artery Bypass Graft Surgery benefit and this benefit is independent of the 180 day separation period.

Lump Sum Cancer Policy Form A72200AR pays a lump sum when the insured is diagnosed with Internal Cancer. The policy also provides a Carcinoma In Situ Benefit that pays $2,000 upon a covered person's onset date of Carcinoma In Situ. There is also a benefit for cancer related death that pays $5,000 when a covered person suffers a cancer related death. These events must be separated by 180 days.

The policies will be marketed to applicant's age 18 through 70 on a payroll, union, or large account basis. Coverage will terminate on the policy anniversary date after the policyholder's 75th birthday. The same applies to the spouse if covered.

Lump Sum Cancer Benefit Rider Form A72050 provides benefits for Cancer only. This rider is only available with Lump Sum Critical Illness Policy Form A72100AR. If the Lump Sum Cancer Benefit Rider is purchased on the Lump Sum Critical Illness policy, the Cancer benefits will be paid independently of the base. However, all covered Cancer benefits as identified in the rider must be separated by 180 days in order to receive payment.

Return of Premium Benefit Rider Form A72051 provides for a maximum refund of premiums paid if both the policy and rider remain in force for 20 consecutive years. This rider is available with Lump Sum Critical Illness Policy Form A72100AR and Lump Sum Cancer Policy Form A72200AR.

Sudden Cardiac Death Benefit Rider Form A72052 provides benefits in the event an insured dies due to sudden cardiac arrest. This rider is only available with Lump Sum Critical Illness Policy Form A72100AR.

The following forms will be used to apply for coverage as follows:

APPLICATION	**UW (underwriting)**	**POLICY**	**RIDERS**
Payroll Application Form A72PAPPAR	LSCI	A72100AR	A72050, and A72052
Payroll Cancer Application A72PCAPPAR	LSCA	A72200AR	A72051
Large Account Application A72GAPPAR	LSCIG	A72100AR	A72050, and A72052
Large Account Cancer Application Form A72GCAPPAR	LSCAG	A72200AR	A72051
Union Application A72UAPPAR	LSCI	A72100AR	A72050, and A72052
Union Cancer Application A72UCAPPAR	LSCA	A72200AR	A72051

Application Forms A72PAPPAR, A72GAPPAR, A72UAPPAR, A72PCAPPAR, A72GCAPPAR, and A72UCAPPAR will be used to collect the personal information and select the type of coverage desired. Underwriting Forms LSCI, LSCA, LSCIG, and LSCAG will be used to answer the underwriting questions. Forms AsigncAR and AsignAR will be used to collect the applicant's and agent's signature. These forms differ in that Form AsigncAR contains an agent's certification statement. Form AsignAR does NOT contain the agent's certification statement and will be used in situations where the associate/agent is unable to be present at the time of application. When the final application prints and is attached to the policy at the time of issue, the application form, the underwriting form, and a signature page will be combined to reflect a complete application.

Brackets are included around the "Check Coverage Desired" section in all applicable application forms to allow us to change the coverage offered if needed. For example, if one of our accounts requests a specific "coverage package" we would be able to adjust the coverage desired section to accommodate their requests.

Reinstatement Application Forms A72003AR and A72003GAR will be used to reinstate a lapsed policy. Form A72003AR will be used for reinstatement of policies on a payroll or union basis and Form A72003GAR will be used to reinstate a lapsed policy on a large account.

Outline of Coverage Forms A72125 and A72225 will be delivered at the time of application and are self-explanatory. Outline of Coverage Form A72125 will be used with Policy Form A72100AR and Outline of Coverage Form A72225 will be used with Policy Form A72200AR.

I certify that the forms submitted herewith meet the applicable provisions of Rule and Regulation 18 of the Arkansas Insurance Department Regulations as well as meeting the applicable requirements of Arkansas Insurance Department.

I certify the following form complies with the requirements of Rule and Regulation 49 of the Arkansas Insurance Department Regulations, Life and Disability Guaranty Fund Notices.

This is to certify that the following forms comply with the requirements of Arkansas Statute Annotated Sections 23-80-201 through 23-80-208, cited as the Life and Disability Insurance Policy Language Simplification Act.

I certify that the enclosed forms meet the minimum reading ease score for the FLESCH test. I further certify the scores for each form are as follows:

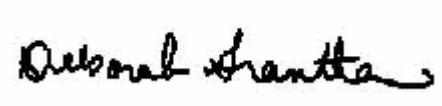
	FLESCH Score	**Grade Level**
Policy Form A72100AR	50.000	10
Policy Form A72200AR	50.548	10
Rider Form A72050	79.209	4
Rider Form A72051	97.705	1
Rider Form A72052	96.279	1
Payroll Application Form A72PAPPAR	46.438	11
Payroll Application From A72PCAPPAR	61.033	7
Union Application Form A72UAPPAR	62.272	7
Union Application Form A72UCAPPAR	59.131	8
Large Account Application A72GAPPAR	60.005	7
Large Account Application A72GCAPPAR	62.869	7
Underwriting Application Form LSCI	64.983	6
Underwriting Application Form LSCIG	73.386	6
Underwriting Application Form LSCA	70.804	5
Underwriting Application Form LSCAG	69.255	5
Reinstatement Application Form A72003AR	75.695	4
Reinstatement Application Form A72003GAR	71.189	5
Signature Form AsignAR	66.891	7
Signature Form AsigncAR	74.252	4
Outline of Coverage Form A72125	62.659	6
Outline of Coverage Form A72225	69.610	5

An actuarial memorandum and rate sheets are enclosed for your review and approval. The appropriate filing fee and/or certification form are also included.

Aflac reserves the right to alter the format of the forms without re-filing due to future technology changes, i.e. paper size, font, font type, line ending or page ending changes. Be assured that any minimum font-size requirements will be met. Any changes to wording or content would be filed for prior approval. We have included brackets in all forms around the address, telephone number, web site, and officer signatures in the event these change in the future. We also reserve the right to use these forms in an electronic format, but Aflac certifies we will retain the filed final print format.

This filing has been prepared by Connie Gates. Should you have any questions or comments concerning this submission, please do not hesitate to call her collect at (706) 596-5048, by fax at (706) 660-7080 or email at cgates@aflac.com.

Sincerely,



Deborah T. Grantham
DTG/CG/cg
Enclosures

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)

[Worldwide Headquarters: 1932 WYNNTON ROAD, COLUMBUS, GEORGIA 31999
TOLL-FREE 1-800-99-AFLAC (1-800-992-3522)]

The policy described in this Outline of Coverage provides supplemental coverage and will be issued only to supplement insurance already in force.

LIMITED BENEFIT, LUMP SUM CRITICAL ILLNESS INSURANCE
Outline of Coverage for Policy Form Series A72100
THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.

If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide furnished by Aflac.

(1) Read Your Policy Carefully: This Outline of Coverage provides a very brief description of some of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and Aflac. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

(2) Lump Sum Critical Illness Insurance Coverage is designed to supplement your existing accident and sickness coverage only when certain losses occur as a result of Critical Illness Events. Critical Illness Events are: Heart Attack, Stroke, Major Human Organ Transplant, End-Stage Renal Failure, Paralysis, or Coma. Coverage is provided for the benefits outlined in Part (3). The benefits described in Part (3) may be limited by Part (5).

(3) Benefits: Subject to the Pre-existing Condition Limitations, Limitations and Exclusions, and all other policy provisions, we will pay the following benefits for a covered Critical Illness Event that occurs while coverage is in force.

For any benefit to be payable, the Onset Date of the Loss must occur on or after the Effective Date of coverage and while coverage is in force. If more than one Loss per Covered Person occurs on the same day, only the highest eligible benefit will be paid. Aflac will not accept an assignment of these benefits. All benefits will be payable to you. Any accrued benefits unpaid at your death will be paid to your estate.

A. MAJOR CRITICAL ILLNESS EVENT BENEFIT: Aflac will pay [$ _____] upon a Covered Person's Onset Date of any of the following Critical Illness Events:

1) Heart Attack
2) Stroke
3) End-Stage Renal Failure
4) Coma
5) Paralysis
6) Major Human Organ Transplant

After qualifying for this benefit, such Covered Person will again become eligible for this benefit after five years from the later of (1) the Onset Date of any Critical Illness Event of such Covered Person or (2) the latest hospitalization or surgery due to such Covered Person's Critical Illness Event. No lifetime maximum.

B. SUBSEQUENT CRITICAL ILLNESS EVENT BENEFIT: After a Covered Person has previously qualified for benefits under Benefit A above, Aflac will pay $5,000 upon that Covered Person's Onset Date of:

1) a **recurrence** of that **same** Critical Illness Event or
2) an occurrence of a **different** Critical Illness Event.

For this benefit to be payable, the Onset Date of the Critical Illness Event must be 180 days or more from the Onset Date of any previously paid Critical Illness Event for such Covered Person. This benefit is not payable on the same day as the Major Critical Illness Event Benefit. No lifetime maximum.

C. CORONARY ARTERY BYPASS GRAFT SURGERY BENEFIT: Aflac will pay $3,000 when a Covered Person undergoes Coronary Artery Bypass Graft Surgery. This benefit is payable once per Covered Person, per lifetime.

(4) Optional Benefits:

LUMP SUM CANCER BENEFIT RIDER: (Series A72050) Applied for ❑ Yes ❑ No

This rider is issued on the basis that the information shown on the application is correct and complete. If any answers on your application for this rider are incorrect or incomplete, the benefits under this rider will be the lesser of the benefits that you would have been eligible to purchase if a correct or complete answer had been given or your original rider benefit amount. Any overpayment of premium will be refunded to you, less any claims paid.

While this coverage is in force, we will pay the following benefits, as applicable, subject to the Pre-existing Condition Limitations, Limitations and Exclusions, and all other policy provisions unless modified herein.

For benefits to be payable, the Onset Date of the Loss must occur on or after the Effective Date of coverage, while coverage is in force, and must be separated by 180 days or more from the Onset Date of any other covered Loss. If more than one Loss per Covered Person occurs within 180 days, only the highest eligible benefit will be paid. Aflac will not accept an assignment of these benefits. All benefits will be payable to you. Any accrued benefits unpaid at your death will be paid to your estate.

A. INTERNAL CANCER BENEFIT: Aflac will pay [$_____] upon a Covered Person's Onset Date of Internal Cancer. This benefit is payable once per Covered Person, per lifetime.

B. CARCINOMA IN SITU BENEFIT: Aflac will pay $2,000 upon a Covered Person's Onset Date of Carcinoma In Situ. This benefit is payable once per Covered Person, per lifetime.

C. CANCER-RELATED DEATH BENEFIT: Aflac will pay $5,000 when a Covered Person suffers a Cancer-Related Death.

Exceptions, Reductions and Limitations of Rider A72050 Series:

A. Benefits are not provided for premalignant conditions or conditions with malignant potential (unless specifically covered); complications of cancer; or any other disease, sickness, or incapacity. Aflac will not pay benefits for recurrence, direct extension, or metastatic spread of any cancer diagnosed prior to the Effective Date of coverage.

B. Aflac will not pay benefits for any Loss that is caused by a Pre-existing Condition unless the Onset Date is more than 12 months after the Effective Date of coverage. Benefits are payable for only one covered Loss at a time per Covered Person.

C. Aflac will not pay benefits for a Loss that is diagnosed outside the territorial limits of the United States, its possessions, or the countries of Canada and Mexico.

D. Aflac will not pay benefits whenever coverage provided by this rider is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

E. For benefits to be payable, the Onset Date must occur on or after the Effective Date of coverage, while coverage is in force and must be separated by 180 days or more from the Onset Date of any other covered Loss. If more than one Loss per Covered Person occurs within 180 days, only the highest eligible benefit will be paid.

F. Aflac will not pay benefits for Skin Cancers.

RETURN OF PREMIUM BENEFIT: (Series A72051) Applied for ❑ Yes ❑ No

Aflac will pay you a cash value based upon the annualized premium paid for this rider, the policy, and any other attached benefit riders **(premium paid for the policy and other attached benefit riders will be calculated at the original premium in effect on the rider Effective Date and will not include premium increases that may occur for the policy or other such riders)**. All Return of Premium Benefits/cash values paid will be less any claims paid. If you surrender this rider for its cash value after the Onset Date of a Loss but before claims are submitted, we will reduce subsequent claim payment(s) by the amount of the cash value paid. Both the policy and the rider must remain in force for 20 consecutive years for you to obtain a maximum refund of premiums paid.

The cash value for premium paid for the policy and rider begins on the fifth rider anniversary date.

Your cash value is based upon annualized premium of **xxxxxxx**. If you surrender this rider after its fifth anniversary and such surrender occurs between rider anniversaries, a prorated amount for the partial year will be paid. The proration will be calculated by taking the cash value difference between the last and next anniversary dates, dividing by 12, and multiplying by the number of months that premiums were earned in the partial year at the time of surrender. This proration will then be added to the cash value on the last rider anniversary date, and this will be the cash value paid.

IMPORTANT! READ CAREFULLY: This rider will terminate on the earlier of: its 20th anniversary date and payment of the cash value; your surrender of it for its cash value between the fifth and 20th anniversary dates; your death prior to its 20th anniversary date, in which case the cash value (if any) will be paid to your estate; your failure to pay the premium for this rider, in which case any cash values due will be paid; the policy's termination, in which case any cash values due will be paid; or the time that claims paid equal or exceed the cash value that would be paid on the 20th policy anniversary. When this rider terminates (is no longer in force), no further premium will be charged for it.

SUDDEN CARDIAC DEATH BENEFIT RIDER: (Series A72052) Applied for ❑ Yes ❑ No

While this coverage is in force, we will pay the following benefit, as applicable, subject to the Pre-existing Condition Limitations, Limitations and Exclusions, and all other policy provisions unless modified herein.

For benefits to be payable, the Onset Date must occur on or after the Effective Date of coverage, while coverage is in force, and must be separated by 180 days or more from the Onset Date of any previously paid Critical Illness Event for such Covered Person. If Sudden Cardiac Death occurs within 180 days of a Critical Illness Event for the same Covered Person, only the highest eligible benefit will be paid. If Coronary Artery Bypass Graft Surgery and Sudden Cardiac Death occur on the same day, only the highest eligible benefit will be paid. Aflac will not accept an assignment of these benefits. All benefits will be payable to you or your estate.

A. SUDDEN CARDIAC DEATH BENEFIT: Aflac will pay [$_____] upon a Covered Person's Onset Date of Sudden Cardiac Death. This benefit is payable once per Covered Person, per lifetime.

(5) Exceptions, Reductions and Limitations of the Policy (This is not a daily hospital expense plan.):

A. Aflac will not pay benefits for any Loss that is caused by a Pre-existing Condition unless it begins more than 12 months after the Effective Date of coverage. Benefits are payable for only one covered Loss at a time per Covered Person.

B. Aflac will not pay benefits for any event that is diagnosed or treated outside the territorial limits of the United States, its possessions, or the countries of Canada and Mexico.

C. Aflac will not pay benefits whenever coverage provided by this policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

D. For any benefit to be payable, the Onset Date of the Loss must occur on or after the Effective Date of coverage and while coverage is in force. If more than one Loss per Covered Person occurs on the same day, only the highest eligible benefit will be paid.

E. This policy does not cover Loss caused by or resulting from:

1. Using any drug, narcotic, hallucinogen, or chemical substance (unless administered by a Physician and taken according to the Physician's instructions) or voluntarily taking any kind of poison or inhaling any kind of gas or fumes;
2. Participating in, or attempting to participate in, an illegal activity that is defined as a felony, whether charged or not ("felony" is as defined by the law of the jurisdiction in which the activity takes place); or being incarcerated in any type penal institution;
3. Intentionally self-inflicting a bodily injury or committing or attempting suicide, while sane or insane;
4. Being exposed to war or any act of war, declared or undeclared;
5. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve.

A Pre-existing Condition is an illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Benefits for a Loss that is caused by a Pre-existing Condition will not be covered unless the Onset Date is more than 12 months after the Effective Date of coverage.

(6) Renewability: The policy is guaranteed-renewable for your lifetime by payment of the premium in effect at the beginning of each renewal period. Premium rates may change only if changed on all policies of the same form number and class in force in your state.

RETAIN FOR YOUR RECORDS.
THIS OUTLINE OF COVERAGE IS ONLY A BRIEF SUMMARY OF THE COVERAGE PROVIDED.
THE POLICY ITSELF SHOULD BE CONSULTED TO DETERMINE
GOVERNING CONTRACTUAL PROVISIONS.

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)

[Worldwide Headquarters: 1932 WYNNTON ROAD, COLUMBUS, GEORGIA 31999
TOLL-FREE 1-800-99-AFLAC (1-800-992-3522)]

The policy described in this Outline of Coverage provides supplemental coverage and will be issued only to supplement insurance already in force.

LIMITED BENEFIT, LUMP SUM CANCER INSURANCE
Outline of Coverage for Policy Form Series A72200
THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.

If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide furnished by Aflac.

(1) Read Your Policy Carefully: This Outline of Coverage provides a very brief description of some of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and Aflac. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

(2) Lump Sum Cancer Insurance Coverage is designed to supplement your existing accident and sickness coverage only when certain losses occur as a result of cancer. Coverage is provided for the benefits outlined in Part (3). The benefits described in Part (3) may be limited by Part (5).

(3) Benefits: Subject to the Pre-existing Condition Limitations, Limitations and Exclusions, and all other policy provisions, we will pay the following benefits for a covered cancer that occurs while coverage is in force.

For benefits to be payable, the Onset Date of the Loss must occur on or after the Effective Date of coverage, while coverage is in force, and must be separated by 180 days or more from the Onset Date of any other covered Loss for such Covered Person. If more than one Loss per Covered Person occurs within 180 days, only the highest eligible benefit will be paid. Aflac will not accept an assignment of these benefits. All benefits will be payable to you. Any accrued benefits unpaid at your death will be paid to your estate.

A. INTERNAL CANCER BENEFIT: Aflac will pay [$_____] upon a Covered Person's Onset Date of Internal Cancer. This benefit is payable once per Covered Person, per lifetime.

B. CARCINOMA IN SITU BENEFIT: Aflac will pay $2,000 upon a Covered Person's Onset Date of Carcinoma In Situ. This benefit is payable once per Covered Person, per lifetime.

C. CANCER-RELATED DEATH BENEFIT: Aflac will pay $5,000 when a Covered Person suffers a Cancer-Related Death.

(4) Optional Benefits:

RETURN OF PREMIUM BENEFIT: (Series A72051) Applied for ❑ Yes ❑ No

Aflac will pay you a cash value based upon the annualized premium paid for this rider, the policy, and any other attached benefit riders **(premium paid for the policy and other attached benefit riders will be calculated at the original premium in effect on the rider Effective Date and will not include premium increases that may occur for the policy or other such riders)**. All Return of Premium Benefits/cash values paid will be less any claims paid. If you surrender this rider for its cash value after the Onset Date of a Loss but before

claims are submitted, we will reduce subsequent claim payment(s) by the amount of the cash value paid. Both the policy and the rider must remain in force for 20 consecutive years for you to obtain a maximum refund of premiums paid.

The cash value for premium paid for the policy and rider begins on the fifth rider anniversary date.

Your cash value is based upon annualized premium of **xxxxxxx**. If you surrender this rider after its fifth anniversary and such surrender occurs between rider anniversaries, a prorated amount for the partial year will be paid. The proration will be calculated by taking the cash value difference between the last and next anniversary dates, dividing by 12, and multiplying by the number of months that premiums were earned in the partial year at the time of surrender. This proration will then be added to the cash value on the last rider anniversary date, and this will be the cash value paid.

IMPORTANT! READ CAREFULLY: This rider will terminate on the earlier of: its 20th anniversary date and payment of the cash value; your surrender of it for its cash value between the fifth and 20th anniversary dates; your death prior to its 20th anniversary date, in which case the cash value (if any) will be paid to your estate; your failure to pay the premium for this rider, in which case any cash values due will be paid; the policy's termination, in which case any cash values due will be paid; or the time that claims paid equal or exceed the cash value that would be paid on the 20th policy anniversary. When this rider terminates (is no longer in force), no further premium will be charged for it.

(5) Exceptions, Reductions and Limitations of the Policy (This is not a daily hospital expense plan.):

A. Benefits are not provided for premalignant conditions or conditions with malignant potential (unless specifically covered); complications of cancer; or any other disease, sickness, or incapacity. Aflac will not pay benefits for recurrence, direct extension, or metastatic spread of any cancer diagnosed prior to the Effective Date of coverage.

B. Aflac will not pay benefits for any Loss that is caused by a Pre-existing Condition unless the Onset Date is more than 12 months after the Effective Date of coverage. Benefits are payable for only one covered Loss at a time per Covered Person.

C. Aflac will not pay benefits for a Loss that is diagnosed outside the territorial limits of the United States, its possessions, or the countries of Canada and Mexico.

D. Aflac will not pay benefits whenever coverage provided by this policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

E. For benefits to be payable, the Onset Date must occur on or after the Effective Date of coverage, while coverage is in force and must be separated by 180 days or more from the Onset Date of any other covered Loss. If more than one Loss per Covered Person occurs within 180 days, only the highest eligible benefit will be paid.

F. Aflac will not pay benefits for Skin Cancers.

A Pre-existing Condition is an illness, disease, infection, or disorder for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Benefits for a Loss that is caused by a Pre-

existing Condition will not be covered unless the Onset Date is more than 12 months after the Effective Date of coverage.

(6) Renewability: The policy is guaranteed-renewable for your lifetime by payment of the premium in effect at the beginning of each renewal period. Premium rates may change only if changed on all policies of the same form number and class in force in your state.

RETAIN FOR YOUR RECORDS.
THIS OUTLINE OF COVERAGE IS ONLY A BRIEF SUMMARY OF THE COVERAGE PROVIDED.
THE POLICY ITSELF SHOULD BE CONSULTED TO DETERMINE
GOVERNING CONTRACTUAL PROVISIONS.

ARKANSAS
INSURANCE
DEPARTMENT

400 University Tower Building
1123 South University Avenue
Little Rock, Arkansas 72204

501-686-2900

ATTN: LIFE & HEALTH DIVISION, ARKANSAS INSURANCE DEPARTMENT

Company Name: AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (Aflac)

Company NAIC Code: 60380

Company Contact Person & Telephone # Connie Gates (706) 596-5048

* *

ALL FEES ARE PER EACH INSURER, PER ANNUAL STATEMENT LINE OF BUSINESS, UNLESS OTHERWISE INDICATED.

FEE SCHEDULE FOR ADMITTED INSURERS

RATE/FORM FILINGS

Life and/or disability policy form filing and review, per each policy, contract, annuity form, per each insurer, per each filing.	* 2 x $50 = $100 ** Retaliatory
Life and/or Disability – Filing and review of each rate filing or loss ration guarantee filing, per each insurer.	* 1 x $50 = $50 ** Retaliatory
Life and/or Disability Policy, Contract or annuity Forms: Filing and review of each certificate, rider, endorsement or application if each is filed separately from the basic form.	* 19 x $20 = $380 ** Retaliatory
Policy and contract forms, all lines, filing corrections in previously filed policy and contract forms.	* ____x $20 = ______ ** Retaliatory
Life and/or Disability: Filing and review of insurer's advertisements, per advertisement, per each insurer.	* ____x $25 = ______ ** Retaliatory

AMEND CERTIFICATE OF AUTHORITY

Review and processing of information to amend an Insurer's Certificate of Authority * ____ x $400 = _____

Filing to amend Certificate of Authority *** ____ x $100 = _____

* THESE FEES ARE PAYABLE UNDER THE OLD FEE SCHEDULE AS OUTLINED UNDER ARK. CODE ANN. 23-63-102, RETALIATORY TAX.

*** THESE FEES ARE PAYABLE AS REQUIRED IN ARK. ANN. § 23-61-401.

SERFF Tracking Number:	*AFLA-125856287*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*40777*
Company Tracking Number:	*A72000*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Lump Sum Critical Illness*		
Project Name/Number:	*Lump Sum Critical Illness & Lump Sum Cancer/*		

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Signature Form	10/13/2008	AsignAR.pdf
No original date	Form	Outline of Coverage	10/13/2008	A72125.pdf
No original date	Supporting Document	Outline of Coverage	10/13/2008	A72125.pdf A72225.pdf
No original date	Form	Outline of Coverage	10/13/2008	A72225.pdf
No original date	Form	Lump Sum Critical Illness Policy	10/13/2008	A72100AR.pdf
No original date	Form	Lump Sum Cancer Policy	10/13/2008	A72200AR.pdf
No original date	Form	Payroll Application	10/13/2008	A72PAPPAR.pdf
No original date	Form	Payroll Application	10/13/2008	A72PCAPPAR.pdf
No original date	Form	Union Application	10/13/2008	A72UAPPAR.pdf
No original date	Form	Union Application	10/13/2008	A72UCAPPAR.pdf

SERFF Tracking Number:	*AFLA-125856287*	*State:*	*Arkansas*
Filing Company:	*American Family Life Assurance Company of Columbus*	*State Tracking Number:*	*40777*
Company Tracking Number:	*A72000*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*Lump Sum Critical Illness*		
Project Name/Number:	*Lump Sum Critical Illness & Lump Sum Cancer/*		

No original date	Form	Large Account Application	10/13/2008	A72GAPPAR.pdf
No original date	Form	Large Account Application	10/13/2008	A72GCAPPAR.pdf

American Family Life Assurance Company of Columbus (Aflac)
[Worldwide Headquarters: Columbus, Georgia 31999]

I, the undersigned Proposed Insured/Employee, agree that by signing below I am submitting an application to Aflac for the following insurance policy(ies).

- ❑ Lump Sum Critical Illness
- ❑ Lump Sum Cancer
- ❑ Short Term Disability
- ❑ Accident
- ❑ Dental
- ❑ Hospital Confinement
- ❑ Specified Health Event
- ❑ Vision
- ❑ Specified Disease/Cancer
- ❑ Hospital Intensive Care

- This is an electronic application. It has been completed and signed by me electronically without the presence of an associate/agent.
- I verify that the unique identifier used to sign this application is mine and that by clicking the "Accept" button I am signing the application(s) electronically. I further understand, agree, and authorize my employer to deduct the premiums for this policy(ies) from my paycheck.
- I would prefer to receive an electronic copy of my policy(ies) instead of paper. ❑ Yes ❑ No

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed and Dated at _____ on _____
City and State Date

Proposed Insured's/Employee's Signature _____

Writing Associate/Agent: Please complete the following – it will become part of the policy.
AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC),
CLIENT SERVICES AND ADMINISTRATION,
[WORLDWIDE HEADQUARTERS • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999.]

Associate/Agent's Name _____

Associate/Agent's Address _____ Telephone _____

If we at Aflac fail to provide you with reasonable and adequate service, you should feel free to contact:
ARKANSAS INSURANCE DEPARTMENT – CONSUMER SERVICES DIVISION
1200 WEST THIRD STREET, LITTLE ROCK, ARKANSAS, 72201-1904, TELEPHONE (501) 371-2640 OR TOLL-FREE 1-800-852-5494.

MAKE CHECK OR MONEY ORDER PAYABLE TO AFLAC.
[FOR INFORMATION, CALL TOLL-FREE 1-800-99-AFLAC (1-800-992-3522).
VISIT OUR WEB SITE AT AFLAC.COM.]

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)

[Worldwide Headquarters: 1932 WYNNTON ROAD, COLUMBUS, GEORGIA 31999
TOLL-FREE 1-800-99-AFLAC (1-800-992-3522)]

The policy described in this Outline of Coverage provides supplemental coverage and will be issued only to supplement insurance already in force.

LIMITED BENEFIT, LUMP SUM CRITICAL ILLNESS INSURANCE
Outline of Coverage for Policy Form Series A72100
THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.

If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide furnished by Aflac.

(1) Read Your Policy Carefully: This Outline of Coverage provides a very brief description of some of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and Aflac. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

(2) Lump Sum Critical Illness Insurance Coverage is designed to supplement your existing accident and sickness coverage only when certain losses occur as a result of Critical Illness Events. Critical Illness Events are: Heart Attack, Stroke, Major Human Organ Transplant, End-Stage Renal Failure, Paralysis, or Coma. Coverage is provided for the benefits outlined in Part (3). The benefits described in Part (3) may be limited by Part (5).

(3) Benefits: Subject to the Pre-existing Condition Limitations, Limitations and Exclusions, and all other policy provisions, we will pay the following benefits for a covered Critical Illness Event that occurs while coverage is in force.

For any benefit to be payable, the Onset Date of the Loss must occur on or after the Effective Date of coverage and while coverage is in force. If more than one Loss per Covered Person occurs on the same day, only the highest eligible benefit will be paid. Aflac will not accept an assignment of these benefits. All benefits will be payable to you. Any accrued benefits unpaid at your death will be paid to your estate.

A. MAJOR CRITICAL ILLNESS EVENT BENEFIT: Aflac will pay [$ _____] upon a Covered Person's Onset Date of any of the following Critical Illness Events:

1) Heart Attack
2) Stroke
3) End-Stage Renal Failure
4) Coma
5) Paralysis
6) Major Human Organ Transplant

After qualifying for this benefit, such Covered Person will again become eligible for this benefit after five years from the later of (1) the Onset Date of any Critical Illness Event of such Covered Person or (2) the latest hospitalization or surgery due to such Covered Person's Critical Illness Event. No lifetime maximum.

B. SUBSEQUENT CRITICAL ILLNESS EVENT BENEFIT: After a Covered Person has previously qualified for benefits under Benefit A above, Aflac will pay $5,000 upon that Covered Person's Onset Date of:

1) a **recurrence** of that **same** Critical Illness Event or
2) an occurrence of a **different** Critical Illness Event.

For this benefit to be payable, the Onset Date of the Critical Illness Event must be 180 days or more from the Onset Date of any previously paid Critical Illness Event for such Covered Person. This benefit is not payable on the same day as the Major Critical Illness Event Benefit. No lifetime maximum.

C. CORONARY ARTERY BYPASS GRAFT SURGERY BENEFIT: Aflac will pay $3,000 when a Covered Person undergoes Coronary Artery Bypass Graft Surgery. This benefit is payable once per Covered Person, per lifetime.

(4) Optional Benefits:

LUMP SUM CANCER BENEFIT RIDER: (Series A72050) Applied for ❑ Yes ❑ No

This rider is issued on the basis that the information shown on the application is correct and complete. If any answers on your application for this rider are incorrect or incomplete, the benefits under this rider will be the lesser of the benefits that you would have been eligible to purchase if a correct or complete answer had been given or your original rider benefit amount. Any overpayment of premium will be refunded to you, less any claims paid.

While this coverage is in force, we will pay the following benefits, as applicable, subject to the Pre-existing Condition Limitations, Limitations and Exclusions, and all other policy provisions unless modified herein.

For benefits to be payable, the Onset Date of the Loss must occur on or after the Effective Date of coverage, while coverage is in force, and must be separated by 180 days or more from the Onset Date of any other covered Loss. If more than one Loss per Covered Person occurs within 180 days, only the highest eligible benefit will be paid. Aflac will not accept an assignment of these benefits. All benefits will be payable to you. Any accrued benefits unpaid at your death will be paid to your estate.

A. INTERNAL CANCER BENEFIT: Aflac will pay [$_____] upon a Covered Person's Onset Date of Internal Cancer. This benefit is payable once per Covered Person, per lifetime.

B. CARCINOMA IN SITU BENEFIT: Aflac will pay $2,000 upon a Covered Person's Onset Date of Carcinoma In Situ. This benefit is payable once per Covered Person, per lifetime.

C. CANCER-RELATED DEATH BENEFIT: Aflac will pay $5,000 when a Covered Person suffers a Cancer-Related Death.

Exceptions, Reductions and Limitations of Rider A72050 Series:

A. Benefits are not provided for premalignant conditions or conditions with malignant potential (unless specifically covered); complications of cancer; or any other disease, sickness, or incapacity. Aflac will not pay benefits for recurrence, direct extension, or metastatic spread of any cancer diagnosed prior to the Effective Date of coverage.

B. Aflac will not pay benefits for any Loss that is caused by a Pre-existing Condition unless the Onset Date is more than 12 months after the Effective Date of coverage. Benefits are payable for only one covered Loss at a time per Covered Person.

C. Aflac will not pay benefits for a Loss that is diagnosed outside the territorial limits of the United States, its possessions, or the countries of Canada and Mexico.

D. Aflac will not pay benefits whenever coverage provided by this rider is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

E. For benefits to be payable, the Onset Date must occur on or after the Effective Date of coverage, while coverage is in force and must be separated by 180 days or more from the Onset Date of any other covered Loss. If more than one Loss per Covered Person occurs within 180 days, only the highest eligible benefit will be paid.

F. Aflac will not pay benefits for Skin Cancers.

RETURN OF PREMIUM BENEFIT: (Series A72051) Applied for ❑ Yes ❑ No

Aflac will pay you a cash value based upon the annualized premium paid for this rider, the policy, and any other attached benefit riders **(premium paid for the policy and other attached benefit riders will be calculated at the original premium in effect on the rider Effective Date and will not include premium increases that may occur for the policy or other such riders)**. All Return of Premium Benefits/cash values paid will be less any claims paid. If you surrender this rider for its cash value after the Onset Date of a Loss but before claims are submitted, we will reduce subsequent claim payment(s) by the amount of the cash value paid. Both the policy and the rider must remain in force for 20 consecutive years for you to obtain a maximum refund of premiums paid.

The cash value for premium paid for the policy and rider begins on the fifth rider anniversary date.

Your cash value is based upon annualized premium of **xxxxxxx**. If you surrender this rider after its fifth anniversary and such surrender occurs between rider anniversaries, a prorated amount for the partial year will be paid. The proration will be calculated by taking the cash value difference between the last and next anniversary dates, dividing by 12, and multiplying by the number of months that premiums were earned in the partial year at the time of surrender. This proration will then be added to the cash value on the last rider anniversary date, and this will be the cash value paid.

IMPORTANT! READ CAREFULLY: This rider will terminate on the earlier of: its 20th anniversary date and payment of the cash value; your surrender of it for its cash value between the fifth and 20th anniversary dates; your death prior to its 20th anniversary date, in which case the cash value (if any) will be paid to your estate; your failure to pay the premium for this rider, in which case any cash values due will be paid; the policy's termination, in which case any cash values due will be paid; or the time that claims paid equal or exceed the cash value that would be paid on the 20th policy anniversary. When this rider terminates (is no longer in force), no further premium will be charged for it.

SUDDEN CARDIAC DEATH BENEFIT RIDER: (Series A72052) Applied for ❑ Yes ❑ No

While this coverage is in force, we will pay the following benefit, as applicable, subject to the Pre-existing Condition Limitations, Limitations and Exclusions, and all other policy provisions unless modified herein.

For benefits to be payable, the Onset Date must occur on or after the Effective Date of coverage, while coverage is in force, and must be separated by 180 days or more from the Onset Date of any previously paid Critical Illness Event for such Covered Person. If Sudden Cardiac Death occurs within 180 days of a Critical Illness Event for the same Covered Person, only the highest eligible benefit will be paid. If Coronary Artery Bypass Graft Surgery and Sudden Cardiac Death occur on the same day, only the highest eligible benefit will be paid. Aflac will not accept an assignment of these benefits. All benefits will be payable to you or your estate.

A. SUDDEN CARDIAC DEATH BENEFIT: Aflac will pay [$_____] upon a Covered Person's Onset Date of Sudden Cardiac Death. This benefit is payable once per Covered Person, per lifetime.

(5) Exceptions, Reductions and Limitations of the Policy (This is not a daily hospital expense plan.):

A. Aflac will not pay benefits for any Loss that is caused by a Pre-existing Condition unless it begins more than 12 months after the Effective Date of coverage. Benefits are payable for only one covered Loss at a time per Covered Person.

B. Aflac will not pay benefits for any event that is diagnosed or treated outside the territorial limits of the United States, its possessions, or the countries of Canada and Mexico.

C. Aflac will not pay benefits whenever coverage provided by this policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

D. For any benefit to be payable, the Onset Date of the Loss must occur on or after the Effective Date of coverage and while coverage is in force. If more than one Loss per Covered Person occurs on the same day, only the highest eligible benefit will be paid.

E. This policy does not cover Loss caused by or resulting from:

1. Using any drug, narcotic, hallucinogen, or chemical substance (unless administered by a Physician and taken according to the Physician's instructions) or voluntarily taking any kind of poison or inhaling any kind of gas or fumes;
2. Participating in, or attempting to participate in, an illegal activity that is defined as a felony, whether charged or not ("felony" is as defined by the law of the jurisdiction in which the activity takes place); or being incarcerated in any type penal institution;
3. Intentionally self-inflicting a bodily injury or committing or attempting suicide, while sane or insane;
4. Being exposed to war or any act of war, declared or undeclared;
5. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve;

A Pre-existing Condition is an illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Benefits for a Loss that is caused by a Pre-existing Condition will not be covered unless the Onset Date is more than 12 months after the Effective Date of coverage.

(6) Renewability: The policy is guaranteed-renewable to age 75 by payment of the premium in effect at the beginning of each renewal period. Premium rates may change only if changed on all policies of the same form number and class in force in your state. **Coverage under the policy will terminate on the policy anniversary date following a Covered Person's 75th birthday.**

RETAIN FOR YOUR RECORDS.
THIS OUTLINE OF COVERAGE IS ONLY A BRIEF SUMMARY OF THE COVERAGE PROVIDED.
THE POLICY ITSELF SHOULD BE CONSULTED TO DETERMINE
GOVERNING CONTRACTUAL PROVISIONS.

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)

[Worldwide Headquarters: 1932 WYNNTON ROAD, COLUMBUS, GEORGIA 31999
TOLL-FREE 1-800-99-AFLAC (1-800-992-3522)]

The policy described in this Outline of Coverage provides supplemental coverage and will be issued only to supplement insurance already in force.

LIMITED BENEFIT, LUMP SUM CANCER INSURANCE
Outline of Coverage for Policy Form Series A72200
THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.

If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide furnished by Aflac.

(1) Read Your Policy Carefully: This Outline of Coverage provides a very brief description of some of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and Aflac. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

(2) Lump Sum Cancer Insurance Coverage is designed to supplement your existing accident and sickness coverage only when certain losses occur as a result of cancer. Coverage is provided for the benefits outlined in Part (3). The benefits described in Part (3) may be limited by Part (5).

(3) Benefits: Subject to the Pre-existing Condition Limitations, Limitations and Exclusions, and all other policy provisions, we will pay the following benefits for a covered cancer that occurs while coverage is in force.

For benefits to be payable, the Onset Date of the Loss must occur on or after the Effective Date of coverage, while coverage is in force, and must be separated by 180 days or more from the Onset Date of any other covered Loss for such Covered Person. If more than one Loss per Covered Person occurs within 180 days, only the highest eligible benefit will be paid. Aflac will not accept an assignment of these benefits. All benefits will be payable to you. Any accrued benefits unpaid at your death will be paid to your estate.

A. INTERNAL CANCER BENEFIT: Aflac will pay [$_____] upon a Covered Person's Onset Date of Internal Cancer. This benefit is payable once per Covered Person, per lifetime.

B. CARCINOMA IN SITU BENEFIT: Aflac will pay $2,000 upon a Covered Person's Onset Date of Carcinoma In Situ. This benefit is payable once per Covered Person, per lifetime.

C. CANCER-RELATED DEATH BENEFIT: Aflac will pay $5,000 when a Covered Person suffers a Cancer-Related Death.

(4) Optional Benefits:

RETURN OF PREMIUM BENEFIT: (Series A72051) Applied for ❑ Yes ❑ No

Aflac will pay you a cash value based upon the annualized premium paid for this rider, the policy, and any other attached benefit riders **(premium paid for the policy and other attached benefit riders will be calculated at the original premium in effect on the rider Effective Date and will not include premium increases that may occur for the policy or other such riders)**. All Return of Premium Benefits/cash values paid will be less any claims paid. If you surrender this rider for its cash value after the Onset Date of a Loss but before claims are submitted, we will reduce subsequent claim payment(s) by the amount of the cash

value paid. Both the policy and the rider must remain in force for 20 consecutive years for you to obtain a maximum refund of premiums paid.

The cash value for premium paid for the policy and rider begins on the fifth rider anniversary date.

Your cash value is based upon annualized premium of **xxxxxxx**. If you surrender this rider after its fifth anniversary and such surrender occurs between rider anniversaries, a prorated amount for the partial year will be paid. The proration will be calculated by taking the cash value difference between the last and next anniversary dates, dividing by 12, and multiplying by the number of months that premiums were earned in the partial year at the time of surrender. This proration will then be added to the cash value on the last rider anniversary date, and this will be the cash value paid.

IMPORTANT! READ CAREFULLY: This rider will terminate on the earlier of: its 20th anniversary date and payment of the cash value; your surrender of it for its cash value between the fifth and 20th anniversary dates; your death prior to its 20th anniversary date, in which case the cash value (if any) will be paid to your estate; your failure to pay the premium for this rider, in which case any cash values due will be paid; the policy's termination, in which case any cash values due will be paid; or the time that claims paid equal or exceed the cash value that would be paid on the 20th policy anniversary. When this rider terminates (is no longer in force), no further premium will be charged for it.

(5) Exceptions, Reductions and Limitations of the Policy (This is not a daily hospital expense plan.):

A. Benefits are not provided for premalignant conditions or conditions with malignant potential (unless specifically covered); complications of cancer; or any other disease, sickness, or incapacity. Aflac will not pay benefits for recurrence, direct extension, or metastatic spread of any cancer diagnosed prior to the Effective Date of coverage.

B. Aflac will not pay benefits for any Loss that is caused by a Pre-existing Condition unless the Onset Date is more than 12 months after the Effective Date of coverage. Benefits are payable for only one covered Loss at a time per Covered Person.

C. Aflac will not pay benefits for a Loss that is diagnosed outside the territorial limits of the United States, its possessions, or the countries of Canada and Mexico.

D. Aflac will not pay benefits whenever coverage provided by this policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

E. For benefits to be payable, the Onset Date must occur on or after the Effective Date of coverage, while coverage is in force and must be separated by 180 days or more from the Onset Date of any other covered Loss. If more than one Loss per Covered Person occurs within 180 days, only the highest eligible benefit will be paid.

F. Aflac will not pay benefits for Skin Cancers.

A Pre-existing Condition is an illness, disease, infection, or disorder for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Benefits for a Loss that is caused by a Pre-existing Condition will not be covered unless the Onset Date is more than 12 months after the Effective Date of coverage.

(6) Renewability: The policy is guaranteed-renewable to age 75 by payment of the premium in effect at the beginning of each renewal period. Premium rates may change only if changed on all policies of the same form number and class in force in your state. **Coverage under the policy will terminate on the policy anniversary date following a Covered Person's 75th birthday.**

RETAIN FOR YOUR RECORDS.
THIS OUTLINE OF COVERAGE IS ONLY A BRIEF SUMMARY OF THE COVERAGE PROVIDED.
THE POLICY ITSELF SHOULD BE CONSULTED TO DETERMINE
GOVERNING CONTRACTUAL PROVISIONS.

LUMP SUM CRITICAL ILLNESS LIMITED BENEFIT HEALTH INSURANCE COVERAGE

NOTICE TO BUYER: THIS IS A LUMP SUM CRITICAL ILLNESS POLICY. IT PAYS BENEFITS FOR CRITICAL ILLNESSES ONLY. READ IT CAREFULLY WITH THE OUTLINE OF COVERAGE, IF APPLICABLE.

The Named Insured as shown in the Policy Schedule will be referred to as "you," "your," or "yours." **American Family Life Assurance Company of Columbus (Aflac),** a stock company, will be referred to as "we," "our," "us," or "Aflac."

CONSIDERATION

This policy is issued in consideration of statements made in your application and the payment of the premium shown in the Policy Schedule. A copy of your application is attached and is a part of this policy. The following paragraphs set forth the definitions of terms, the limitations and exclusions, the insurance benefits, and other provisions.

YOUR RIGHT TO EXAMINE THIS POLICY

It is important to us that you are satisfied with this policy. If you are not satisfied, you may return it within 30 days after you receive it. Send it to your associate (duly licensed agent) or to Aflac [Worldwide Headquarters, 1932 Wynnton Road, Columbus, Georgia 31999]. You will receive a full refund of all premiums paid, and your policy will be void from its Effective Date. If you return this policy, please note in writing: "This policy is returned for cancellation and refund of premium."

IMPORTANT NOTICE

Please read your application attached to this policy. This policy is issued on the basis that the information shown on the application is correct and complete. Statements made in the application are deemed representations and not warranties. Carefully check the application. Write to us within 30 days of the date you receive this policy if any information on the application is not correct or complete. Incorrect or incomplete information may result in the denial of claims or voiding of the policy. No associate (duly licensed agent) may change this policy or waive any of its provisions.

THIS POLICY IS GUARANTEED-RENEWABLE TO AGE 75, SUBJECT TO AFLAC'S RIGHT TO CHANGE PREMIUMS BY CLASS UPON ANY RENEWAL DATE.

We agree that this policy will never be restricted by the addition of any rider without your consent, nor will renewal be refused because of any change in any Covered Person's health or physical condition. You are guaranteed the right to renew this policy until the policy anniversary date following your 75th birthday by the timely payment of premiums at the rate in effect at the beginning of each term. **Coverage under this policy will terminate on the policy anniversary date following a Covered Person's 75th birthday.**

Aflac may change the established premium rate, but only if the rate is changed for all policies of this class. While this policy is in force, no change will be made in your class because of the age, sex, or physical condition of any Covered Person. "Class" means all policies of this form number and premium classification in your state that are then in force. If the established premium rate changes, Aflac will notify you in writing at your last known address, as shown in our records, at least 30 days before the change becomes effective.

PRE-EXISTING CONDITION LIMITATIONS

A Pre-existing Condition is an illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Benefits for a Loss that is caused by a Pre-existing Condition will not be covered unless the Onset Date is more than 12 months after the Effective Date of coverage.

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)
CLIENT SERVICES AND ADMINISTRATION
[WORLDWIDE HEADQUARTERS • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999
FOR ASSISTANCE OR INFORMATION ABOUT THIS POLICY,
CALL 1-800-99-AFLAC (1-800-992-3522).
FOR CLAIM FORMS, VISIT OUR WEB SITE AT AFLAC.COM.]
If we at Aflac, fail to provide you with reasonable and adequate service,
you should feel free to contact:
ARKANSAS INSURANCE DEPARTMENT - CONSUMER SERVICES DIVISION
1200 WEST THIRD STREET, LITTLE ROCK, ARKANSAS 72201-1904
Telephone (501) 371- 2640 or Toll-Free 1-800-852-5494.

INDEX

Policy Schedule

NAMED INSURED:	John A. Doe	**POLICY NUMBER:**	111-2222
TYPE OF COVERAGE:	Individual	**COVERAGE:**	XXXXXX AAABBB
MODE OF PAYMENT:	Monthly		

PREMIUMS:		**EFFECTIVE DATE:**
Policy:	$xxxxxx	Policy: XX/XX/XXXX
Rider:	$xxxxxx	Rider: XX/XX/XXXX
Rider:	$xxxxxx	Rider: XX/XX/XXXX
Rider:	$xxxxxx	Rider: XX/XX/XXXX

	BENEFIT AMOUNT (per Covered Person):
Policy:	
Major Critical Illness Event Benefit:	$XXXX
Cancer Benefit Rider:	
Internal Cancer Benefit:	$XXXX
Sudden Cardiac Death Benefit Rider:	
Sudden Cardiac Death Benefit:	$XXXX

In witness whereof, Aflac's president and secretary signed this policy in Columbus, Georgia, as of the policy Effective Date shown in the Policy Schedule.

[

Paul S. Amos II, President

Joey M. Loudermilk, Secretary]

This policy is a legal contract between you and Aflac.
READ YOUR POLICY CAREFULLY.

Part 1
DEFINITIONS

A. COMA: a continuous state of profound unconsciousness, diagnosed or treated on or after the Effective Date of coverage, classified on the Glasgow Coma Scale as seven or below and characterized by the absence of (1) spontaneous eye movements, (2) response to painful stimuli, and (3) vocalization. The condition must require intubation for respiratory assistance. The term "Coma" does not include any medically induced coma.

B. CORONARY ARTERY BYPASS GRAFT SURGERY: open-heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, but excluding procedures such as but not limited to coronary angioplasty, valve replacement surgery, stent placement, laser relief, or other surgical or nonsurgical procedures.

C. COVERED PERSON: any person insured under Individual, Named Insured/Spouse Only, One-Parent Family, or Two-Parent Family coverage. See Type of Coverage definition.

D. CRITICAL ILLNESS EVENT: Heart Attack, Stroke, Major Human Organ Transplant, End-Stage Renal Failure, Paralysis, or Coma.

E. DEPENDENT CHILDREN: your natural children, stepchildren, or legally adopted children who are: (1) unmarried; (2) under age 25; and (3) legal dependents for tax exemption purposes under the United States Internal Revenue Service Tax Code. **A Dependent Child must be under age 25 at the time of application to be eligible for coverage.** Coverage of a Dependent Child will terminate on the anniversary date of this policy following the child's 25th birthday. Coverage provided under any One-Parent or Two-Parent Family policy will include any other unmarried Dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became so incapacitated prior to age 25 and while covered under this policy. You must furnish proof of continued incapacity and dependency at Aflac's request, but not more often than annually, after the two-year period following the Dependent Child's 25th birthday.

F. EFFECTIVE DATE: the date(s) coverage begins as shown in the Policy Schedule. The Effective Date of this policy **is not** the date you signed the application for coverage.

G. END-STAGE RENAL FAILURE: permanent and irreversible kidney failure, not of an acute nature, requiring dialysis or a kidney transplant to maintain life.

H. HEART ATTACK: a myocardial infarction, coronary thrombosis, or coronary occlusion. The attack must be positively diagnosed by a Physician and must be evidenced by electrocardiographic findings or clinical findings together with blood enzyme findings. The definition of "Heart Attack" shall not be construed to mean congestive heart failure, atherosclerotic heart disease, angina, coronary artery disease, cardiac arrest, or any other dysfunction of the cardiovascular system. **Sudden Cardiac Arrest is not a Heart Attack.**

I. IMMEDIATE FAMILY: anyone related to you in the following manner: spouse; brothers or sisters (includes stepbrothers and stepsisters); children (includes stepchildren); parents (includes stepparents); grandchildren; father- or mother-in-law; brother- or sister-in-law; and spouses, as applicable, of any of these.

J. INJURY: a bodily injury caused directly by an accident, independent of Sickness, disease, bodily infirmity, or any other cause, occurring on or after the Effective Date of coverage and while coverage is in force.

K. LOSS: a Critical Illness Event or Coronary Artery Bypass Graft Surgery.

L. MAJOR HUMAN ORGAN TRANSPLANT: a surgery that was first recommended by a member of the medical profession after the Effective Date of coverage in which a Covered Person receives, as a result of a surgical transplant, one or more of the following human organs: heart, kidney, liver, lung, or pancreas. **It does not include transplants involving mechanical or nonhuman organs.**

M. ONSET DATE: the date of the occurrence for a Heart Attack or Stroke; the date of diagnosis for End-Stage Renal Failure, Paralysis, or Coma; or the date of surgery for a Major Human Organ Transplant or Coronary Artery Bypass Graft Surgery.

N. PARALYSIS: complete and total loss of use of two or more limbs (paraplegia, quadriplegia, or hemiplegia) for a continuous period of at least 30 days as the result of a spinal cord Injury. The Paralysis must be confirmed by your attending Physician.

O. PHYSICIAN: a person legally qualified to practice medicine, other than you or a member of your Immediate Family, who is licensed as a Physician by the state where treatment is received to treat the type of condition for which a claim is made.

P. SICKNESS: an illness, disease, infection, or any other abnormal physical condition, independent of Injury, occurring on or after the Effective Date of coverage and while coverage is in force.

Q. STROKE: apoplexy due to rupture or acute occlusion of a cerebral artery. The apoplexy must cause complete or partial loss of function involving the motion or sensation of a part of the body and must last more than 24 hours. The Stroke must be positively diagnosed by a Physician based upon documented neurological deficits and confirmatory neuroimaging studies. “Stroke” does not mean head injury, transient ischemic attack (TIA), or cerebrovascular insufficiency.

R. SUDDEN CARDIAC ARREST: sudden, unexpected loss of heart function in which the heart abruptly and without warning stops working as a result of an internal electrical system malfunction of the heart. **Sudden Cardiac Arrest is not a Heart Attack.**

S. TYPE OF COVERAGE: see your Policy Schedule to determine the Type of Coverage issued: Individual, Named Insured/Spouse Only, One-Parent Family, or Two-Parent Family.

1. **Individual:** coverage for only you (the Named Insured listed in the Policy Schedule).

2. **Named Insured/Spouse Only:** coverage for you (the Named Insured) and your spouse. “Your spouse” is defined as the person to whom you are legally married and who is listed on your application.

3. **One-Parent Family:** coverage for you (the Named Insured) and all of your Dependent Children.

4. **Two-Parent Family:** coverage for you (the Named Insured), your spouse, and all of your Dependent Children (or those of your spouse).

Newborn children are automatically covered under the terms of this policy from the moment of birth. Adopted children are covered from the date of the filing of the petition. If this is an Individual or Named Insured/Spouse Only policy, newborn children are automatically covered from the moment of birth, and adopted children are covered from the date of the filing of the petition if the Named Insured applies for coverage within 60 days after the filing of the petition for adoption. However, coverage shall begin from the moment of birth if the petition for adoption and application for coverage are filed within 60 days after the birth of the minor. This coverage shall terminate upon the dismissal or denial of a petition for adoption. Coverage for newborn or adopted children will be in effect through the 90th day following the date of such event. If you desire uninterrupted coverage for a newborn or an adopted child, you must notify Aflac within 90 days of the child's birth or the date the petition for adoption is filed or before the next premium due date, whichever is later. Upon notification, Aflac will convert this policy to One-Parent Family or Two-Parent Family coverage and advise you of the additional premium due. If One-Parent Family or Two-Parent Family coverage is in force, it is not necessary for you to notify Aflac of the birth of your child or the date of the filing of the petition for adoption of a child, and an additional premium payment will not be required. If you desire any other person(s) to be covered after the Effective Date of this policy, you must apply for such coverage, and that person must be added by endorsement. The added person(s) will be subject to the Pre-existing Condition Limitations. If Two-Parent Family coverage is already in force, an additional premium will not be required. Insurance for persons added by endorsement becomes effective on the date specified on the endorsement.

The insurance on any Dependent Child will terminate on the anniversary date of this policy following the Dependent Child's 25th birthday, on the date the child marries, or at the time the child no longer qualifies as a legal dependent for tax exemption purposes under the United States Internal Revenue Service Tax Code, whichever occurs first (for continuation of coverage information, see Part 3, Right of Conversion). Termination will be without prejudice to any claim originating prior to the date of termination. Aflac's acceptance of premium after such date will be considered as premium for only the remaining persons who qualify as Covered Persons under this policy. When coverage on all Dependent Children terminates, you must notify Aflac, in writing, and elect whether to continue this policy on an Individual or Named Insured/Spouse Only basis. After such notice, Aflac will arrange for the payment of the appropriate premium due, including returning any unearned premium. Coverage provided under any One-Parent Family or Two-Parent Family policy will continue to include any other unmarried Dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became so incapacitated prior to age 25 and while covered under this policy. You must furnish proof of continued incapacity and dependency at Aflac's request, but not more often than annually, after the two-year period following the Dependent Child's 25th birthday.

Part 2
LIMITATIONS AND EXCLUSIONS

A. Aflac will not pay benefits for any Loss that is caused by a Pre-existing Condition unless it begins more than 12 months after the Effective Date of coverage. Benefits are payable for only one covered Loss at a time per Covered Person.

B. Aflac will not pay benefits for any event that is diagnosed or treated outside the territorial limits of the United States, its possessions, or the countries of Canada and Mexico.

C. Aflac will not pay benefits whenever coverage provided by this policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

D. For any benefit to be payable, the Onset Date of the Loss must occur on or after the Effective Date of coverage and while coverage is in force. If more than one Loss per Covered Person occurs on the same day, only the highest eligible benefit will be paid.

E. This policy does not cover Loss caused by or resulting from:

1. Using any drug, narcotic, hallucinogen, or chemical substance (unless administered by a Physician and taken according to the Physician's instructions) or voluntarily taking any kind of poison or inhaling any kind of gas or fumes;

2. Participating in, or attempting to participate in, an illegal activity that is defined as a felony, whether charged or not ("felony" is as defined by the law of the jurisdiction in which the activity takes place); or being incarcerated in any type penal institution;

3. Intentionally self-inflicting a bodily injury or committing or attempting suicide, while sane or insane;

4. Being exposed to war or any act of war, declared or undeclared;

5. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve;

Part 3
RIGHT OF CONVERSION

A. DISSOLUTION OF MARRIAGE: If you and your spouse dissolve your marriage by a valid decree of dissolution and your ex-spouse was covered under a Named Insured/Spouse Only or Two-Parent Family policy, your ex-spouse's coverage will terminate. Your ex-spouse may then apply for and receive, without evidence of insurability, a policy providing coverage not greater than the terminated coverage. To obtain the policy, your ex-spouse must make application to Aflac within 60 days following the entry of the decree of dissolution of marriage and pay the appropriate premium for the policy. If such dissolution of marriage occurs, the Named Insured under this policy at the time of the dissolution will retain that status. Any Dependent Children may be covered under either policy, but not both.

B. DEATH: In the event of your death, your spouse, if alive and covered under this policy, will become the Named Insured. All benefits accrued prior to your death will be paid to your estate.

C. TERMINATION OF DEPENDENCY: A Dependent Child whose dependency has terminated and who desires to continue coverage as a Named Insured under a separate policy may do so by notifying Aflac of the request in writing. Such person will have the right to apply for an equivalent policy without evidence of insurability and without interruption in coverage, provided Aflac receives written notification of the request prior to 31 days after the anniversary date of this policy following the date he or she is no longer considered a Dependent Child.

D. TERMINATION DUE TO AGE: Your coverage will terminate on the policy anniversary date following your 75th birthday. At that time, your spouse, if alive and covered under this policy, will become the Named Insured.

Part 4
UNIFORM PROVISIONS

A. ENTIRE CONTRACT; CHANGES: This policy, together with the application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance. No change in this policy is valid until approved in writing by the president and secretary of Aflac at our worldwide headquarters. Any such change must be noted hereon or attached hereto. No associate (duly licensed agent) has the authority to change this policy or to waive any of its provisions.

B. TIME LIMIT ON CERTAIN DEFENSES: After two years from the Effective Date of this policy, any misstatements, except fraudulent misstatements, made by you in the application will not be used to void this policy or to deny a claim commencing after the expiration of such two-year period. Any claim for Loss commencing after 12 months from the Effective Date of coverage shall not be reduced on the grounds that a physical condition, not excluded from coverage by name or specific description, had existed prior to the Effective Date of coverage. Coverage for Pre-existing Conditions will not be reduced or denied after the policy has been in force 12 months.

C. TERM: You are guaranteed the right to renew this policy until the policy anniversary date following your 75th birthday by the timely payment of premiums at the rate in effect at the beginning of each term. Your coverage will terminate on the policy anniversary date following your 75th birthday. The term of this policy begins at midnight, standard time, at the place where you reside on the Effective Date shown in the Policy Schedule. It ends at midnight, at the same standard time, on the first renewal date. Each renewal term ends at midnight, at the same standard time, on the next following renewal date. Renewal dates are determined by the mode of payment. The mode of payment for the original term of this policy is shown in the Policy Schedule. An annual premium will maintain this policy in force for 12 months, semiannual for six months, quarterly for three months, and monthly for one month. Premium for a term is due on the first day of that term. **If you fail to pay your premium by the end of the grace period, coverage under this policy will terminate**.

D. GRACE PERIOD: A grace period of 31 days will be granted for the payment of each premium falling due after the first premium. During the grace period, this policy will continue in force.

E. REINSTATEMENT: You may request reinstatement of your policy from your associate (duly licensed agent) or from Aflac. If your policy has lapsed for nonpayment of premium and we accept a later payment without requiring an application, your policy will be reinstated. If we require a written application and provide you with a conditional receipt, your policy will be reinstated upon our approval of the application. If we do not notify you of our disapproval in writing within 45 days of the date your application is received at our worldwide headquarters, your policy will be deemed reinstated. The reinstated policy will cover only Loss with an Onset Date on or after the date of reinstatement. In all other respects, you and Aflac will have the same rights as provided under the policy immediately before the due date of the defaulted premium, subject to any provisions added in connection with the reinstatement. Any premium accepted in connection with a reinstatement will be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

F. NOTICE OF CLAIM: Written notice of claim must be given within 60 days after a covered Loss starts or as soon as reasonably possible. The notice can be given to Aflac at our worldwide headquarters, [1932 Wynnton Rd, Columbus, GA 31999], or to your associate (duly licensed agent). The notice of claim should include the name of the Covered Person and the policy number.

G. CLAIM FORMS: When we receive a notice of claim, we will send you forms for filing proof of loss. If the forms are not given to you within ten working days after the giving of such notice, you will meet the proof-of-loss requirements by giving us a written statement of the nature and extent of the Loss within the time limit stated in the Proof of Loss provision.

H. PROOF OF LOSS: Written proof of loss must be furnished to Aflac at our worldwide headquarters within 90 days after the date of such Loss. Failure to furnish such proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than 15 months from the time proof is otherwise required.

I. TIME OF PAYMENT OF CLAIMS: All benefits payable under this policy will be paid immediately upon receipt of due written proof of loss.

J. PAYMENT OF CLAIMS: All benefits will be payable to you. Any accrued benefits unpaid at your death will be paid to your estate.

K. LEGAL ACTIONS: No legal action may be brought to recover on this policy within 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action may be brought after three years from the time written proof of loss is required to be furnished.

L. PHYSICAL EXAMINATIONS AND AUTOPSY: Aflac, at its own expense, will have the right and opportunity to examine a Covered Person when and as often as it may be reasonably required during the pendency of a claim hereunder, and to make an autopsy in the case of death where autopsy is not forbidden by law.

M. CONFORMITY WITH STATE AND FEDERAL STATUTES: Any provision of this policy that on its Effective Date is in conflict with the statutes of the state in which it was issued or with any federal statute is hereby amended to conform to the minimum requirements of such statutes.

N. OTHER INSURANCE WITH AFLAC: If any person is covered under more than one Aflac policy or rider with Critical Illness, Specified Health Event, or Cancer benefits, only the one chosen by you or your estate, as the case may be, will be effective. Aflac will return all premiums paid for that person for all other Critical Illness, Specified Health Event, or Cancer policies and riders from the date of duplication, less any benefits paid.

O. REFUND OF UNEARNED PREMIUMS: That portion of the premium paid for a period beyond the end of the policy month in which the Named Insured died shall be paid in a lump sum on a date no later than 30 days after the proof of the Named Insured's death has been furnished to Aflac. Exception: Where Named Insured/Spouse, One-Parent Family or Two-Parent Family coverage is continued, no refund is applicable.

Should the Named Insured cancel this policy prior to its renewal date, Aflac will refund to the Named Insured the unearned portion of such premiums paid for any period beyond the end of the policy month in which the cancellation occurred.

Part 5
BENEFITS

While this coverage is in force, we will pay the following benefits, as applicable, subject to the Pre-existing Condition Limitations, Limitations and Exclusions, and all other policy provisions.

For any benefit to be payable, the Onset Date of the Loss must occur on or after the Effective Date of coverage and while coverage is in force. If more than one Loss per Covered Person occurs on the same day, only the highest eligible benefit will be paid. Aflac will not accept an assignment of these benefits. All benefits will be payable to you. Any accrued benefits unpaid at your death will be paid to your estate.

A. MAJOR CRITICAL ILLNESS EVENT BENEFIT: Aflac will pay [$ _____] upon a Covered Person's Onset Date of any of the following Critical Illness Events:

1) Heart Attack
2) Stroke
3) End-Stage Renal Failure
4) Coma
5) Paralysis
6) Major Human Organ Transplant

After qualifying for this benefit, such Covered Person will again become eligible for this benefit after five years from the later of (1) the Onset Date of any Critical Illness Event of such Covered Person or (2) the latest hospitalization or surgery due to such Covered Person's Critical Illness Event. No lifetime maximum.

B. SUBSEQUENT CRITICAL ILLNESS EVENT BENEFIT: After a Covered Person has previously qualified for benefits under Benefit A above, Aflac will pay $5,000 upon that Covered Person's Onset Date of:

1) a **recurrence** of that **same** Critical Illness Event or
2) an occurrence of a **different** Critical Illness Event.

For this benefit to be payable, the Onset Date of the Critical Illness Event must be 180 days or more from the Onset Date of any previously paid Critical Illness Event for such Covered Person. This benefit is not payable on the same day as the Major Critical Illness Event Benefit. No lifetime maximum.

C. CORONARY ARTERY BYPASS GRAFT SURGERY BENEFIT: Aflac will pay $3,000 when a Covered Person undergoes Coronary Artery Bypass Graft Surgery. This benefit is payable once per Covered Person, per lifetime.

LUMP SUM CANCER LIMITED BENEFIT HEALTH INSURANCE COVERAGE

NOTICE TO BUYER: THIS IS A LUMP SUM CANCER POLICY. IT PAYS BENEFITS FOR CANCER ONLY. READ IT CAREFULLY WITH THE OUTLINE OF COVERAGE, IF APPLICABLE.

The Named Insured as shown in the Policy Schedule will be referred to as "you," "your," or "yours." **American Family Life Assurance Company of Columbus (Aflac),** a stock company, will be referred to as "we," "our," "us," or "Aflac."

CONSIDERATION

This policy is issued in consideration of statements made in your application and the payment of the premium shown in the Policy Schedule. A copy of your application is attached and is a part of this policy. The following paragraphs set forth the definitions of terms, the limitations and exclusions, the insurance benefits, and other provisions.

YOUR RIGHT TO EXAMINE THIS POLICY

It is important to us that you are satisfied with this policy. If you are not satisfied, you may return it within 30 days after you receive it. Send it to your associate (duly licensed agent) or to Aflac [Worldwide Headquarters, 1932 Wynnton Road, Columbus, Georgia 31999]. You will receive a full refund of all premiums paid, and your policy will be void from its Effective Date. If you return this policy, please note in writing: "This policy is returned for cancellation and refund of premium."

IMPORTANT NOTICE

Please read your application attached to this policy. This policy is issued on the basis that the information shown on the application is correct and complete. Statements made in the application are deemed representations and not warranties. Carefully check the application. Write to us within 30 days of the date you receive this policy if any information on the application is not correct or complete. Incorrect or incomplete information may result in the denial of claims or voiding of the policy. No associate (duly licensed agent) may change this policy or waive any of its provisions.

THIS POLICY IS GUARANTEED-RENEWABLE TO AGE 75, SUBJECT TO AFLAC'S RIGHT TO CHANGE PREMIUMS BY CLASS UPON ANY RENEWAL DATE.

We agree that this policy will never be restricted by the addition of any rider without your consent, nor will renewal be refused because of any change in any Covered Person's health or physical condition. You are guaranteed the right to renew this policy until the policy anniversary date following your 75th birthday by the timely payment of premiums at the rate in effect at the beginning of each term. **Coverage under this policy will terminate on the policy anniversary date following a Covered Person's 75th birthday.**

Aflac may change the established premium rate, but only if the rate is changed for all policies of this class. While this policy is in force, no change will be made in your class because of the age, sex, or physical condition of any Covered Person. "Class" means all policies of this form number and premium classification in your state that are then in force. If the established premium rate changes, Aflac will notify you in writing at your last known address, as shown in our records, at least 30 days before the change becomes effective.

PRE-EXISTING CONDITION LIMITATIONS

A Pre-existing Condition is an illness, disease, infection, or disorder for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Benefits for a Loss that is caused by a Pre-existing Condition will not be covered unless the Onset Date is more than 12 months after the Effective Date of coverage.

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)
CLIENT SERVICES AND ADMINISTRATION
[WORLDWIDE HEADQUARTERS • 1932 WYNNTON ROAD • COLUMBUS, GEORGIA 31999
FOR ASSISTANCE OR INFORMATION ABOUT THIS POLICY,
CALL 1-800-99-AFLAC (1-800-992-3522).
FOR CLAIM FORMS, VISIT OUR WEB SITE AT AFLAC.COM.]
If we at Aflac, fail to provide you with reasonable and adequate service,
you should feel free to contact:
ARKANSAS INSURANCE DEPARTMENT - CONSUMER SERVICES DIVISION
1200 WEST THIRD STREET, LITTLE ROCK, ARKANSAS 72201-1904
Telephone (501) 371- 2640 or Toll-Free 1-800-852-5494.

INDEX

Policy Schedule

NAMED INSURED:	John A. Doe	**POLICY NUMBER:**	111-2222
TYPE OF COVERAGE:	Individual	**COVERAGE:**	XXXXXX AAABBB
MODE OF PAYMENT:	Monthly		

PREMIUMS:
Policy: $xxxxxx
Rider: $xxxxxx

EFFECTIVE DATE:
Policy: XX/XX/XXXX
Rider: XX/XX/XXXX

BENEFIT AMOUNT (per Covered Person):
Internal Cancer Benefit Amount: $XXXX

In witness whereof, Aflac's president and secretary signed this policy in Columbus, Georgia, as of the policy Effective Date shown in the Policy Schedule.

[

Paul S. Amos II, President

Joey M. Loudermilk, Secretary]

This policy is a legal contract between you and Aflac.
READ YOUR POLICY CAREFULLY.

Part 1
DEFINITIONS

A. CANCER-RELATED DEATH: death as a result of Internal Cancer. Internal Cancer must be listed as the primary or a contributing cause of death on the death certificate.

B. CARCINOMA IN SITU: a carcinoma in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

C. COVERED PERSON: any person insured under Individual, Named Insured/Spouse Only, One-Parent Family, or Two-Parent Family coverage. See Type of Coverage definition.

D. DEPENDENT CHILDREN: your natural children, stepchildren, or legally adopted children who are: (1) unmarried; (2) under age 25; and (3) legal dependents for tax exemption purposes under the United States Internal Revenue Service Tax Code. **A Dependent Child must be under age 25 at the time of application to be eligible for coverage.** Coverage of a Dependent Child will terminate on the anniversary date of this policy following the child's 25th birthday. Coverage provided under any One-Parent or Two-Parent Family policy will include any other unmarried Dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became so incapacitated prior to age 25 and while covered under this policy. You must furnish proof of continued incapacity and dependency at Aflac's request, but not more often than annually, after the two-year period following the Dependent Child's 25th birthday.

E. EFFECTIVE DATE: the date(s) coverage begins as shown in the Policy Schedule. The Effective Date of this policy **is not** the date you signed the application for coverage.

F. IMMEDIATE FAMILY: anyone related to you in the following manner: spouse; brothers or sisters (includes stepbrothers and stepsisters); children (includes stepchildren); parents (includes stepparents); grandchildren; father- or mother-in-law; brother- or sister-in-law; and spouses, as applicable, of any of these.

G. INTERNAL CANCER: disease manifested by the presence of a malignant tumor and characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Internal Cancer also includes but is not limited to leukemia, Hodgkin's disease, myeloproliferative and myelodysplastic blood disorders, and invasive melanoma of Clark's Level III or higher, or a Breslow level greater than 1.5 mm. Internal Cancer must receive a Positive Medical Diagnosis. Premalignant conditions or conditions with malignant potential, other than those specifically named above, are not considered Internal Cancer. Internal Cancer does not include Nonmelanoma Skin Cancers, Noninvasive Melanoma Skin Cancers, or Carcinoma In Situ.

H. LOSS: Internal Cancer, Carcinoma In Situ, or Cancer-Related Death.

I. ONSET DATE: the day the tissue specimen, culture, and/or titer is taken upon which the diagnosis of Internal Cancer or Carcinoma In Situ is based. The Onset Date is not the date the diagnosis is communicated to the Covered Person.

J. PHYSICIAN: a person legally qualified to practice medicine, other than you or a member of your Immediate Family, who is licensed as a Physician by the state where treatment is received to treat the type of condition for which a claim is made.

K. POSITIVE MEDICAL DIAGNOSIS: a diagnosis of an Internal Cancer by a Physician who is certified by the American Board of Pathology to practice pathologic anatomy or by a certified osteopathic pathologist. Pathologic interpretation of the histology of skin lesions will be accepted from dermatologists certified by the American Board of Dermatopathology. The diagnosis must be based on a microscopic examination of fixed tissue or preparations from the hemic system (either during life or postmortem). The pathologist making the diagnosis will base judgment solely on the criteria of "malignancy" as accepted by the American Board of Pathology or the Osteopathic Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue, or specimen. A clinical diagnosis of Internal Cancer will be accepted as evidence that Internal Cancer exists when a pathological diagnosis cannot be made, provided medical evidence substantially documents the diagnosis of Internal Cancer. Such pathological report or, if applicable, clinical diagnosis must be submitted to Aflac for benefits to be payable.

L. SKIN CANCER: a cancer that forms in the tissues of the skin and is confined to the skin. There are several types of Skin Cancer. Skin Cancer that forms in melanocytes (skin cells that make pigment) is called melanoma.

1. **NONMELANOMA SKIN CANCER:** a cancer other than a melanoma that begins in the upper part of the skin (epidermis).

2. **NONINVASIVE MELANOMA SKIN CANCER:** a cancer that has not spread outside the tissue in which it began and includes melanoma of Clark's Level I or II, or a Breslow Level less than or equal to 1.5 mm.

M. TYPE OF COVERAGE: see your Policy Schedule to determine the Type of Coverage issued: Individual, Named Insured/Spouse Only, One-Parent Family, or Two-Parent Family.

1. **Individual:** coverage for only you (the Named Insured listed in the Policy Schedule).

2. **Named Insured/Spouse Only:** coverage for you (the Named Insured) and your spouse. "Your spouse" is defined as the person to whom you are legally married and who is listed on your application.

3. **One-Parent Family:** coverage for you (the Named Insured) and all of your Dependent Children.

4. **Two-Parent Family:** coverage for you (the Named Insured), your spouse, and all of your Dependent Children (or those of your spouse).

Newborn children are automatically covered under the terms of this policy from the moment of birth. Adopted children are covered from the date of the filing of the petition. If this is an Individual or Named Insured/Spouse Only policy, newborn children are automatically covered from the moment of birth, and adopted children are covered from the date of the filing of the petition if the Named Insured applies for coverage within 60 days after the filing of the petition for adoption. However, coverage shall begin from the moment of birth if the petition for adoption and application for coverage are filed within 60 days after the birth of the minor. This coverage shall terminate upon the dismissal or denial of a petition for adoption. Coverage for newborn or adopted children will be in effect through the 90th day following the date of such event. If you desire uninterrupted coverage for a newborn or an adopted child, you must notify Aflac within 90 days of the child's birth or the date the petition for adoption is filed or

before the next premium due date, whichever is later. Upon notification, Aflac will convert this policy to One-Parent Family or Two-Parent Family coverage and advise you of the additional premium due. If One-Parent Family or Two-Parent Family coverage is in force, it is not necessary for you to notify Aflac of the birth of your child or the date of the filing of the petition for adoption of a child, and an additional premium payment will not be required. If you desire any other person(s) to be covered after the Effective Date of this policy, you must apply for such coverage, and that person must be added by endorsement. The added person(s) will be subject to the Pre-existing Condition Limitations. If Two-Parent Family coverage is already in force, an additional premium will not be required. Insurance for persons added by endorsement becomes effective on the date specified on the endorsement.

The insurance on any Dependent Child will terminate on the anniversary date of this policy following the Dependent Child's 25th birthday, on the date the child marries, or at the time the child no longer qualifies as a legal dependent for tax exemption purposes under the United States Internal Revenue Service Tax Code, whichever occurs first (for continuation of coverage information, see Part 3, Right of Conversion). Termination will be without prejudice to any claim originating prior to the date of termination. Aflac's acceptance of premium after such date will be considered as premium for only the remaining persons who qualify as Covered Persons under this policy. When coverage on all Dependent Children terminates, you must notify Aflac, in writing, and elect whether to continue this policy on an Individual or Named Insured/Spouse Only basis. After such notice, Aflac will arrange for the payment of the appropriate premium due, including returning any unearned premium. Coverage provided under any One-Parent Family or Two-Parent Family policy will continue to include any other unmarried Dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became so incapacitated prior to age 25 and while covered under this policy. You must furnish proof of continued incapacity and dependency at Aflac's request, but not more often than annually, after the two-year period following the Dependent Child's 25th birthday.

Part 2
LIMITATIONS AND EXCLUSIONS

A. Benefits are not provided for premalignant conditions or conditions with malignant potential (unless specifically covered); complications of cancer; or any other disease, sickness, or incapacity. Aflac will not pay benefits for recurrence, direct extension, or metastatic spread of any cancer diagnosed prior to the Effective Date of coverage.

B. Aflac will not pay benefits for any Loss that is caused by a Pre-existing Condition unless the Onset Date is more than 12 months after the Effective Date of coverage. Benefits are payable for only one covered Loss at a time per Covered Person.

C. Aflac will not pay benefits for a Loss that is diagnosed outside the territorial limits of the United States, its possessions, or the countries of Canada and Mexico.

D. Aflac will not pay benefits whenever coverage provided by this policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

E. For benefits to be payable, the Onset Date must occur on or after the Effective Date of coverage, while coverage is in force, and must be separated by 180 days or more from the Onset Date of any other covered Loss for such Covered Person. If more than one Loss per Covered Person occurs within 180 days, only the highest eligible benefit will be paid.

F. Aflac will not pay benefits for Skin Cancers.

Part 3
RIGHT OF CONVERSION

A. DISSOLUTION OF MARRIAGE: If you and your spouse dissolve your marriage by a valid decree of dissolution and your ex-spouse was covered under a Named Insured/Spouse Only or Two-Parent Family policy, your ex-spouse's coverage will terminate. Your ex-spouse may then apply for and receive, without evidence of insurability, a policy providing coverage not greater than the terminated coverage. To obtain the policy, your ex-spouse must make application to Aflac within 60 days following the entry of the decree of dissolution of marriage and pay the appropriate premium for the policy. If such dissolution of marriage occurs, the Named Insured under this policy at the time of the dissolution will retain that status. Any Dependent Children may be covered under either policy, but not both.

B. DEATH: In the event of your death, your spouse, if alive and covered under this policy, will become the Named Insured. All benefits accrued prior to your death will be paid to your estate.

C. TERMINATION OF DEPENDENCY: A Dependent Child whose dependency has terminated and who desires to continue coverage as a Named Insured under a separate policy may do so by notifying Aflac of the request in writing. Such person will have the right to apply for an equivalent policy without evidence of insurability and without interruption in coverage, provided Aflac receives written notification of the request prior to 31 days after the anniversary date of this policy following the date he or she is no longer considered a Dependent Child.

D. TERMINATION DUE TO AGE: Your coverage will terminate on the policy anniversary date following your 75th birthday. At that time, your spouse, if alive and covered under this policy, will become the Named Insured.

Part 4
UNIFORM PROVISIONS

A. ENTIRE CONTRACT; CHANGES: This policy, together with the application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance. No change in this policy is valid until approved in writing by the president and secretary of Aflac at our worldwide headquarters. Any such change must be noted hereon or attached hereto. No associate (duly licensed agent) has the authority to change this policy or to waive any of its provisions.

B. TIME LIMIT ON CERTAIN DEFENSES: After two years from the Effective Date of this policy, any misstatements, except fraudulent misstatements, made by you in the application will not be used to void this policy or to deny a claim commencing after the expiration of such two-year period. Any claim for Loss commencing after 12 months from the Effective Date of coverage shall not be reduced on the grounds that a physical condition, not excluded from coverage by name or specific description, had existed prior to the Effective Date of coverage. Coverage for Pre-existing Conditions will not be reduced or denied after the policy has been in force 12 months.

C. TERM: You are guaranteed the right to renew this policy until the policy anniversary date following your 75th birthday by the timely payment of premiums at the rate in effect at the beginning of each term. Your coverage will terminate on the policy anniversary date following your 75th birthday. The term of this policy begins at midnight, standard time, at the place where you reside on the Effective Date shown in the Policy Schedule. It ends at midnight, at

the same standard time, on the first renewal date. Each renewal term ends at midnight, at the same standard time, on the next following renewal date. Renewal dates are determined by the mode of payment. The mode of payment for the original term of this policy is shown in the Policy Schedule. An annual premium will maintain this policy in force for 12 months, semiannual for six months, quarterly for three months, and monthly for one month. Premium for a term is due on the first day of that term. **If you fail to pay your premium by the end of the grace period, coverage under this policy will terminate**.

D. GRACE PERIOD: A grace period of 31 days will be granted for the payment of each premium falling due after the first premium. During the grace period, this policy will continue in force.

E. REINSTATEMENT: You may request reinstatement of your policy from your associate (duly licensed agent) or from Aflac. If your policy has lapsed for nonpayment of premium and we accept a later payment without requiring an application, your policy will be reinstated. If we require a written application and provide you with a conditional receipt, your policy will be reinstated upon our approval of the application. If we do not notify you of our disapproval in writing within 45 days of the date your application is received at our worldwide headquarters, your policy will be deemed reinstated. The reinstated policy will cover only Loss with an Onset Date on or after the date of reinstatement. In all other respects, you and Aflac will have the same rights as provided under the policy immediately before the due date of the defaulted premium, subject to any provisions added in connection with the reinstatement. Any premium accepted in connection with a reinstatement will be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

F. NOTICE OF CLAIM: Written notice of claim must be given within 60 days after a covered Loss starts or as soon as reasonably possible. The notice can be given to Aflac at our worldwide headquarters, [1932 Wynnton Rd, Columbus, GA 31999], or to your associate (duly licensed agent). The notice of claim should include the name of the Covered Person and the policy number.

G. CLAIM FORMS: When we receive a notice of claim, we will send you forms for filing proof of loss. If the forms are not given to you within ten working days after the giving of such notice, you will meet the proof-of-loss requirements by giving us a written statement of the nature and extent of the Loss within the time limit stated in the Proof of Loss provision.

H. PROOF OF LOSS: Written proof of loss must be furnished to Aflac at our worldwide headquarters within 90 days after the date of such Loss. Failure to furnish such proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than 15 months from the time proof is otherwise required.

I. TIME OF PAYMENT OF CLAIMS: All benefits payable under this policy will be paid immediately upon receipt of due written proof of loss.

J. PAYMENT OF CLAIMS: All benefits will be payable to you. Any accrued benefits unpaid at your death will be paid to your estate.

K. LEGAL ACTIONS: No legal action may be brought to recover on this policy within 60 days after written proof of loss has been furnished in accordance with the requirements of this

policy. No such action may be brought after three years from the time written proof of loss is required to be furnished.

L. PHYSICAL EXAMINATIONS AND AUTOPSY: Aflac, at its own expense, will have the right and opportunity to examine a Covered Person when and as often as it may be reasonably required during the pendency of a claim hereunder, and to make an autopsy in the case of death where autopsy is not forbidden by law.

M. CONFORMITY WITH STATE AND FEDERAL STATUTES: Any provision of this policy that on its Effective Date is in conflict with the statutes of the state in which it was issued or with any federal statute is hereby amended to conform to the minimum requirements of such statutes.

N. OTHER INSURANCE WITH AFLAC: If any person is covered under more than one Aflac Cancer policy or Cancer rider, only the one chosen by you or your estate, as the case may be, will be effective. Aflac will return all premiums paid for that person for all other Cancer policies or Cancer riders from the date of duplication, less any benefits paid.

O. REFUND OF UNEARNED PREMIUMS: That portion of the premium paid for a period beyond the end of the policy month in which the Named Insured died shall be paid in a lump sum on a date no later than 30 days after the proof of the Named Insured's death has been furnished to Aflac. Exception: Where Named Insured/Spouse, One-Parent Family or Two-Parent Family coverage is continued, no refund is applicable.

Should the Named Insured cancel this policy prior to its renewal date, Aflac will refund to the Named Insured the unearned portion of such premiums paid for any period beyond the end of the policy month in which the cancellation occurred.

Part 5
BENEFITS

While this coverage is in force, we will pay the following benefits, as applicable, subject to the Pre-existing Condition Limitations, Limitations and Exclusions, and all other policy provisions.

For benefits to be payable, the Onset Date of the Loss must occur on or after the Effective Date of coverage, while coverage is in force, and must be separated by 180 days or more from the Onset Date of any other covered Loss for such Covered Person. If more than one Loss per Covered Person occurs within 180 days, only the highest eligible benefit will be paid. Aflac will not accept an assignment of these benefits. All benefits will be payable to you. Any accrued benefits unpaid at your death will be paid to your estate.

A. INTERNAL CANCER BENEFIT: Aflac will pay [$ _____] upon a Covered Person's Onset Date of Internal Cancer. This benefit is payable once per Covered Person, per lifetime.

B. CARCINOMA IN SITU BENEFIT: Aflac will pay $2,000 upon a Covered Person's Onset Date of Carcinoma In Situ. This benefit is payable once per Covered Person, per lifetime.

C. CANCER-RELATED DEATH BENEFIT: Aflac will pay $5,000 when a Covered Person suffers a Cancer-Related Death.

Payroll

LUMP SUM CRITICAL ILLNESS INSURANCE POLICY (A72100 Series)
Supplemental Health Insurance Coverage

Application to: American Family Life Assurance Company of Columbus (Aflac)
[Worldwide Headquarters • Columbus, Georgia 31999]

❑ New
❑ Conversion
Policy Number:

Please Print in Black Ink – To Be Completed by Proposed Insured/Employee

Proposed Insured's/Employee's Name _____ _____ _____
Last First MI

State of Birth_____ DOB _____ Sex _____ Height _____ Weight _____
Month/Day/Year

SSN _____ - _____ - _____
(optional)

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP_____

Home Telephone (___)_____ Business Telephone (___)_____ Best Time to Call _____

E-Mail Address (optional)_____

Are you applying for Dependent Child(ren) coverage? ❑ Yes ❑ No
If Yes, Dependent Children must be under age 25 at the time of application.

Write spouse's name below if you are applying for Two-Parent Family or Named Insured/Spouse Only coverage; if you have no spouse or your spouse is not to be covered, put N/A in the space below.

Spouse's Name _____ _____ _____ DOB _____ Sex _____
Last First MI Month/Day/Year

Payroll Account Name_____ Payroll Account No._____

Name of Employer _____

Is this insurance intended to replace any other health insurance now in force? ❑ Yes ❑ No
If Yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable, and provide the policy number here: _____

Does anyone to be covered have any other Specified Health Event coverage with Aflac? ❑ Yes ❑ No
If Yes, this must be a conversion of that coverage. Please give current policy number and see Applicant's Statements and Agreements concerning conversions.
Policy Number: _____

Does anyone to be covered under the Lump Sum Cancer Benefit Rider have any other Cancer coverage with Aflac? ❑ Yes ❑ No
If Yes, this must be a conversion of that coverage. Please give current policy number and see Applicant's Statements and Agreements concerning conversions. ❑ N/A
Policy Number: _____

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Check Coverage Desired:	[❑ Individual	❑ Named Insured/ Spouse Only	❑ One-Parent Family	❑ Two-Parent Family

	Total No. Units	**Benefit Amount**	**Premium**	
❑ Lump Sum Critical Illness Policy (Series A72100) *Total number of units are limited to [2 to 20] units at $5,000 per unit				☒ After-Tax
Optional Riders:				
❑ Lump Sum Cancer Benefit Rider (Series A72050) **Internal Cancer Benefit Amount will be the same as the Major Critical Illness Event Benefit amount selected.**				
❑ Return of Premium Benefit Rider (Series A72051) Options: ❑ No Rider ❑ New Rider ❑ Retain Current Rider (Factor amt. _____)				
❑ Sudden Cardiac Death Benefit Rider (Series A72052) **Sudden Cardiac Death Benefit Amount will be the same as the Major Critical Illness Event Benefit amount selected.**				
		Total Premium]		

Billing Method:
- ❑ Payroll Deduction
- ❑ Bank Draft (B/D, ACH)
- ❑ Credit Card (C/C)

Mode:
- ❑ 01 Weekly
- ❑ 01 14-Day Biweekly
- ❑ 01 Semimonthly
- ❑ 01 28-Day Biweekly
- ❑ 01 Monthly
- ❑ 03 Quarterly
- ❑ 06 Semiannual
- ❑ 12 Annual

PLEASE NOTE: If B/D, ACH, or C/C billing method is checked, only the following modes of payment are available: Monthly, Quarterly, Semiannual, or Annual.

Employee No. _____ Dept. No. _____ Assoc./Agent's No. _____

Billable Premium $ _____ Premium Collected $ _____ Sit. Code _____

APPLICANT'S STATEMENTS AND AGREEMENTS:

- I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters. It is not the date I signed this application.
- I understand that the policy I am applying for will not cover any person who has attained age 71 before the Effective Date of the policy. The policy is guaranteed renewable to age 75. Coverage will terminate on the policy anniversary date following a Covered Person's 75th birthday.
- I understand that coverage is not provided for an illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Loss caused by a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.
- I understand that unmarried Dependent Children, if any, must be under age 25 at the time of application. Once covered, Dependent Children will continue to be covered until the anniversary date of the policy following their 25th birthday.

- I acknowledge receipt of, if applicable:
  - ❑ Replacement Notice
  - ❑ Outline of Coverage
  - ❑ *Guide To Health Insurance for People with Medicare*

- If this is an application for a conversion of coverage, the following conditions will apply: (1) If anyone covered under the previous policy is not eligible for coverage under the new policy, the policy for which this application is made for the person(s) identified will be void, and coverage will continue for this person only under the terms of the previous policy, if such policy remains in force; (2) The Time Limit on Certain Defenses provision will run from the Effective Date of the new policy, and the original policy will be terminated as of the Effective Date of the new policy; and (3) The Pre-existing Condition Limitations in the new policy will run from the original policy's Effective Date for the benefits provided under the original policy. For the increased benefit amount, the Pre-existing Condition Limitations in the new policy will run from the new policy's Effective Date.

- I understand that (1) the policy of insurance I am now applying for will be issued based upon the written answers to the questions and information asked for in this application and any other pertinent information Aflac may require for proper underwriting; (2) the policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (3) no change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.

- I understand that (1) Aflac is not bound by any statement made by me, or any associate/agent of Aflac, unless written herein and (2) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing.

- I understand that the premium amount listed on this application represents the premium amount that my employer will remit to Aflac on my behalf. I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me on an online enrollment system, if applicable.

- If I am applying to replace existing Aflac coverage with this policy, I acknowledge that the policies may have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current Aflac policy and its benefits for the benefits provided in this Aflac policy.

  Proposed Insured's Initials _____

- I have reviewed the statements and answers I have provided on this application. I understand that this policy is to be issued based upon these statements and answers, and any other pertinent information Aflac may require for proper underwriting. The answers are complete and true. I understand that all statements made in this application are deemed representations and not warranties but that material misrepresentations herein may result in loss of coverage under this policy. I further understand that I am signing this application one time even though I may have used it to apply for more than one policy. No person to be insured is covered by any Title XIX programs such as Medicaid.

- I understand that the purchase of this policy is intended to supplement my existing comprehensive health care coverage. It is not intended to replace or be issued in lieu of that coverage.

NOTICE OF INFORMATION PRACTICES

To issue an insurance policy, Aflac may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by Aflac may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you except information that relates to a claim or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our worldwide headquarters. This notice applies only in Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia.

INFORMATION REGARDING THE MEDICAL INFORMATION BUREAU (MIB)
PRENOTICE

Information regarding your insurability will be treated as confidential. Aflac may, however, make a brief report thereon to MIB, Inc., formerly known as the Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB toll-free at [1-866-692-6901 (TTY 1-866-346-3642)]. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734].

Aflac may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its Web site at www.mib.com.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus (Aflac) or any person or entity acting on its part: any medical professional, medical care institution, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), MIB, Inc., formerly known as the Medical Information Bureau, consumer reporting agency, or employer.

"Information" means facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, driving record, or any other medical or nonmedical facts that Aflac deems appropriate to determine eligibility for insurance or to evaluate a claim for benefits during the time this authorization is valid. I also authorize Aflac to give information to MIB, Inc.

I understand that any disclosure of health information to Aflac for the purpose of determining eligibility for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be redisclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Aflac for enrollment or to determine eligibility for insurance or for underwriting or risk rating (where applicable) purposes and, should coverage be issued, the information may be used to contest a claim for benefits or the issuance of the policy itself during the contestability period provided in the policy.

I understand that Aflac is conditioning the issuance of coverage on the provision of this authorization, and that, while I may refuse to sign this authorization, my refusal to do so could result in coverage not being issued.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac has taken action in reliance on this authorization or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac, [Attn: Policy Service, 1932 Wynnton Road, Columbus, GA 31999].

Unless otherwise revoked, I agree that this authorization will expire on the earlier of the date Aflac notifies me of its declination of my application for coverage or, if a policy is issued, two years from the policy effective date.

I agree that a copy of this authorization is as valid as the original.

For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

* hospitalization
* physician services
* hospice
* outpatient prescription drugs if you are enrolled in Medicare Part D
* other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

* Check the coverage in **all** health insurance policies you already have.
* For more information about Medicare and Medicare Supplement insurance, review the *Choosing a Medigap Policy:* A *Guide to Health Insurance for People with Medicare*, available from the insurance company.
* For help in understanding your health insurance, contact your state insurance department (website = www.accessarkansas.org/insurance) or state health insurance assistance program (SHIP Division of Department at 800-224-6330 or email *Insurance.Seniors@Arkansas.gov*).

Payroll

LUMP SUM CANCER INSURANCE POLICY (A72200 Series)
Supplemental Health Insurance Coverage

Application to: American Family Life Assurance Company of Columbus (Aflac)
[Worldwide Headquarters • Columbus, Georgia 31999]

❑ New
❑ Conversion
Policy Number:

Please Print in Black Ink – To Be Completed by Proposed Insured/Employee

Proposed Insured's/Employee's Name _____ _____ _____
Last First MI

State of Birth_____ DOB _____ Sex _____
Month/Day/Year

SSN _____ - _____ - _____
(optional)

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP_____

Home Telephone (___)_____ Business Telephone (___)_____ Best Time to Call _____

E-Mail Address (optional)_____

Are you applying for Dependent Child(ren) coverage? ❑ Yes ❑ No
If Yes, Dependent Children must be under age 25 at the time of application.

Write spouse's name below if you are applying for Two-Parent Family or Named Insured/Spouse Only coverage; if you have no spouse or your spouse is not to be covered, put N/A in the space below.

Spouse's Name _____ _____ _____ DOB _____ Sex _____
Last First MI Month/Day/Year

Payroll Account Name _____ Payroll Account No. _____

Name of Employer _____

Is this insurance intended to replace any other health insurance now in force? ❑ Yes ❑ No
If Yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable, and provide the policy number here: _____

Does anyone to be covered have any other Cancer coverage with Aflac? ❑ Yes ❑ No
If Yes, this must be a conversion of that coverage. Please give current policy number and see Applicant's Statements and Agreements concerning conversions.
Policy Number: _____

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Check Coverage Desired:	[❑ Individual	❑ Named Insured/ Spouse Only	❑ One-Parent Family	❑ Two-Parent Family

	Total No. Units	**Benefit Amount**	**Premium**	
❑ **Lump Sum Cancer Policy (Series A72200)** ***Total number of units are limited to [2 to 20] units at $5,000 per unit**				☒ After-Tax
Optional Rider:				
❑ **Return of Premium Benefit Rider (Series A72051)** **Options:** ❑ No Rider ❑ New Rider ❑ Retain Current Rider (Factor amt. _____)				
		Total Premium]		

Billing Method:
- ❑ Payroll Deduction
- ❑ Bankdraft (B/D, ACH)
- ❑ Credit Card (C/C)

Mode:
- ❑ 01 Weekly
- ❑ 01 14-Day Biweekly
- ❑ 01 28-Day Biweekly
- ❑ 01 Semimonthly
- ❑ 01 Monthly
- ❑ 03 Quarterly
- ❑ 06 Semiannual
- ❑ 12 Annual

PLEASE NOTE: If B/D, ACH, or C/C billing method is checked, only the following modes of payment are available: Monthly, Quarterly, Semiannual, or Annual.

Employee No. _____ Dept. No. _____ Assoc./Agent's No. _____

Billable Premium $ _____ Premium Collected $ _____ Sit. Code _____

APPLICANT'S STATEMENTS AND AGREEMENTS:

- I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters. It is not the date I signed this application.
- I understand that the policy I am applying for will not cover any person who has attained age 71 before the Effective Date of the policy. The policy is guaranteed renewable to age 75. Coverage will terminate on the policy anniversary date following a Covered Person's 75th birthday.
- I understand that coverage is not provided for an illness, disease, infection, or disorder for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Loss caused by a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.
- I understand that unmarried Dependent Children, if any, must be under age 25 at the time of application. Once covered, Dependent Children will continue to be covered until the anniversary date of the policy following their 25th birthday.
- I acknowledge receipt of, if applicable:
  - ❑ Replacement Notice
  - ❑ Outline of Coverage
  - ❑ *Guide To Health Insurance for People with Medicare*
- If this is an application for a conversion of coverage, the following conditions will apply: (1) If anyone covered under the previous policy is not eligible for coverage under the new policy, the policy for which this application is made for the person(s) identified will be void, and coverage will continue for this person only under the terms of the previous policy, if such policy remains in force; (2) The Time Limit on Certain Defenses provision will run from the Effective

Date of the new policy, and the original policy will be terminated as of the Effective Date of the new policy; and (3) The Pre-existing Condition Limitations in the new policy will run from the original policy's Effective Date for the benefits provided under the original policy. For the increased benefit amount, the Pre-existing Condition Limitations in the new policy will run from the new policy's Effective Date.

- I understand that (1) the policy of insurance I am now applying for will be issued based upon the written answers to the questions and information asked for in this application and any other pertinent information Aflac may require for proper underwriting; (2) the policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (3) no change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.
- I understand that (1) Aflac is not bound by any statement made by me, or any associate/agent of Aflac, unless written herein and (2) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing.
- I understand that the premium amount listed on this application represents the premium amount that my employer will remit to Aflac on my behalf. I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me on an online enrollment system, if applicable.
- If I am applying to replace existing Aflac coverage with this policy, I acknowledge that the policies may have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current Aflac policy and its benefits for the benefits provided in this Aflac policy.

Proposed Insured's Initials _____

- I have reviewed the statements and answers I have provided on this application. I understand that this policy is to be issued based upon these statements and answers, and any other pertinent information Aflac may require for proper underwriting. The answers are complete and true. I understand that all statements made in this application are deemed representations and not warranties but that material misrepresentations herein may result in loss of coverage under this policy. I further understand that I am signing this application one time even though I may have used it to apply for more than one policy. No person to be insured is covered by any Title XIX programs such as Medicaid.
- I understand that the purchase of this policy is intended to supplement my existing comprehensive health care coverage. It is not intended to replace or be issued in lieu of that coverage.

NOTICE OF INFORMATION PRACTICES

To issue an insurance policy, Aflac may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by Aflac may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you except information that relates to a claim or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our worldwide headquarters. This notice applies only in Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia.

INFORMATION REGARDING THE MEDICAL INFORMATION BUREAU (MIB)
PRENOTICE

Information regarding your insurability will be treated as confidential. Aflac may, however, make a brief report thereon to MIB, Inc., formerly known as the Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB toll-free at [1-866-692-6901 (TTY 1-866-346-3642)]. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734].

Aflac may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its Web site at www.mib.com.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus (Aflac) or any person or entity acting on its part: any medical professional, medical care institution, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), MIB, Inc., formerly known as the Medical Information Bureau, consumer reporting agency, or employer.

"Information" means facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, driving record, or any other medical or non-medical facts that Aflac deems appropriate to determine eligibility for insurance or to evaluate a claim for benefits during the time this authorization is valid. I also authorize Aflac to give information to MIB, Inc.

I understand that any disclosure of health information to Aflac for the purpose of determining eligibility for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be re-disclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Aflac for enrollment or to determine eligibility for insurance or for underwriting or risk rating (where applicable) purposes and, should coverage be issued, the information may be used to contest a claim for benefits or the issuance of the policy itself during the contestability period provided in the policy.

I understand that Aflac is conditioning the issuance of coverage on the provision of this authorization, and that, while I may refuse to sign this authorization, my refusal to do so could result in coverage not being issued.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac has taken action in reliance on this authorization or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac, [Attn: Policy Service, 1932 Wynnton Road, Columbus, GA 31999].

Unless otherwise revoked, I agree that this authorization will expire on the earlier of the date Aflac notifies me of its declination of my application for coverage or, if a policy is issued, two years from the policy effective date.

I agree that a copy of this authorization is as valid as the original.

For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

* hospitalization
* physician services
* hospice
* outpatient prescription drugs if you are enrolled in Medicare Part D
* other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

* Check the coverage in **all** health insurance policies you already have.
* For more information about Medicare and Medicare Supplement insurance, review the *Choosing a Medigap Policy:* A *Guide to Health Insurance for People with Medicare*, available from the insurance company.
* For help in understanding your health insurance, contact your state insurance department (website = www.accessarkansas.org/insurance) or state health insurance assistance program (SHIP Division of Department at 800-224-6330 or email *Insurance.Seniors@Arkansas.gov*).

Union

LUMP SUM CRITICAL ILLNESS INSURANCE POLICY (A72100 Series)
Supplemental Health Insurance Coverage

Application to: American Family Life Assurance Company of Columbus (Aflac)
[Worldwide Headquarters • Columbus, Georgia 31999]

❑ New
❑ Conversion
Policy Number:

Please Print in Black Ink – To Be Completed by Proposed Insured

Proposed Insured's Name _____
Last First MI

State of Birth_____ DOB _____ Sex _____ Height _____ Weight _____
Month/Day/Year

SSN _____ - _____ - _____
(optional)

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP_____

Home Telephone (___)_____ Business Telephone (___)_____ Best Time to Call _____

E-Mail Address (optional)_____

Are you applying for Dependent Child(ren) coverage? ❑ Yes ❑ No
If Yes, Dependent Children must be under age 25 at the time of application.

Write spouse's name below if you are applying for Two-Parent Family or Named Insured/Spouse Only coverage; if you have no spouse or your spouse is not to be covered, put N/A in the space below.

Spouse's Name _____ DOB _____ Sex _____
Last First MI Month/Day/Year

Account Name_____ Account No._____

Name of Employer _____

Is this insurance intended to replace any other health insurance now in force? ❑ Yes ❑ No
If Yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable, and provide the policy number here: _____

Does anyone to be covered have any other Specified Health Event coverage with Aflac? ❑ Yes ❑ No
If Yes, this must be a conversion of that coverage. Please give current policy number and see Applicant's Statements and Agreements concerning conversions.
Policy Number: _____

Does anyone to be covered under the Lump Sum Cancer Benefit Rider have any other Cancer coverage with Aflac? ❑ Yes ❑ No ❑ N/A
If Yes, this must be a conversion of that coverage. Please give current policy number and see Applicant's Statements and Agreements concerning conversions.
Policy Number: _____

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Check Coverage Desired:	[❑ Individual	❑ Named Insured/ Spouse Only	❑ One-Parent Family	❑ Two-Parent Family

	Total No. Units	**Benefit Amount**	**Premium**	
❑ **Lump Sum Critical Illness Policy (Series A72100)** ***Total number of units are limited to [2 to 20] units at $5,000 per unit**				☒ After-Tax
Optional Riders:				
❑ **Lump Sum Cancer Benefit Rider (Series A72050)** **Internal Cancer Benefit Amount will be the same as the Major Critical Illness Event Benefit amount selected.**				
❑ **Return of Premium Benefit Rider (Series A72051)** **Options:** ❑ No Rider ❑ New Rider ❑ Retain Current Rider (Factor amt. _____)				
❑ **Sudden Cardiac Death Benefit Rider (Series A72052)** **Sudden Cardiac Death Benefit Amount will be the same as the Major Critical Illness Event Benefit amount selected.**				
		Total Premium]		

Billing Method:
❑ Direct
❑ List Bill
❑ Bank Draft (B/D, ACH)
❑ Credit Card (C/C)

Mode:
❑ 01 Monthly
❑ 03 Quarterly
❑ 06 Semiannual
❑ 12 Annual

Assoc./Agent No. _____ Sit. Code _____ Billable Premium $ _____ Premium Collected $ _____

TO BE COMPLETED BY PROPOSED INSURED

Are you currently working at your primary job with the employer listed on the front of this application? ❑ Yes ❑ No

If you answered No to Question 1 above, a policy will not be issued; therefore, do not submit this application.

APPLICANT'S STATEMENTS AND AGREEMENTS:

- I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters. It is not the date I signed this application.
- I understand that the policy I am applying for will not cover any person who has attained age 71 before the Effective Date of the policy. The policy is guaranteed renewable to age 75. Coverage will terminate on the policy anniversary date following a Covered Person's 75th birthday.
- I understand that coverage is not provided for an illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Loss caused by a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.
- I understand that unmarried Dependent Children, if any, must be under age 25 at the time of application. Once covered, Dependent Children will continue to be covered until the anniversary date of the policy following their 25th birthday.

- I acknowledge receipt of, if applicable:
  - ❑ Replacement Notice
  - ❑ Outline of Coverage
  - ❑ *Guide To Health Insurance for People with Medicare*

- If this is an application for a conversion of coverage, the following conditions will apply: (1) If anyone covered under the previous policy is not eligible for coverage under the new policy, the policy for which this application is made for the person(s) identified will be void, and coverage will continue for this person only under the terms of the previous policy, if such policy remains in force; (2) The Time Limit on Certain Defenses provision will run from the Effective Date of the new policy, and the original policy will be terminated as of the Effective Date of the new policy; and (3) The Pre-existing Condition Limitations in the new policy will run from the original policy's Effective Date for the benefits provided under the original policy. For the increased benefit amount, the Pre-existing Condition Limitations in the new policy will run from the new policy's Effective Date.

- I understand that (1) the policy of insurance I am now applying for will be issued based upon the written answers to the questions and information asked for in this application and any other pertinent information Aflac may require for proper underwriting; (2) the policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (3) no change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.

- I understand that (1) Aflac is not bound by any statement made by me, or any associate/agent of Aflac, unless written herein and (2) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing.

- I understand that the premium amount listed on this application represents the premium amount that my employer will remit to Aflac on my behalf. I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me on an online enrollment system, if applicable.

- If I am applying to replace existing Aflac coverage with this policy, I acknowledge that the policies may have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current Aflac policy and its benefits for the benefits provided in this Aflac policy.

  Proposed Insured's Initials _____

- I have reviewed the statements and answers I have provided on this application. I understand that this policy is to be issued based upon these statements and answers, and any other pertinent information Aflac may require for proper underwriting. The answers are complete and true. I understand that all statements made in this application are deemed representations and not warranties but that material misrepresentations herein may result in loss of coverage under this policy. I further understand that I am signing this application one time even though I may have used it to apply for more than one policy. No person to be insured is covered by any Title XIX programs such as Medicaid.

- I understand that the purchase of this policy is intended to supplement my existing comprehensive health care coverage. It is not intended to replace or be issued in lieu of that coverage.

NOTICE OF INFORMATION PRACTICES

To issue an insurance policy, Aflac may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by Aflac may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you except information that relates to a claim or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our worldwide headquarters. This notice applies only in Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia.

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"Information" means facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, driving record, or any other medical or non-medical facts that Aflac deems appropriate to determine eligibility for insurance or to evaluate a claim for benefits during the time this authorization is valid. I also authorize Aflac to give information to MIB, Inc.

I understand that any disclosure of health information to Aflac for the purpose of determining eligibility for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be re-disclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Aflac for enrollment or to determine eligibility for insurance or for underwriting or risk rating (where applicable) purposes and, should coverage be issued, the information may be used to contest a claim for benefits or the issuance of the policy itself during the contestability period provided in the policy.

I understand that Aflac is conditioning the issuance of coverage on the provision of this authorization, and that, while I may refuse to sign this authorization, my refusal to do so could result in coverage not being issued.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac has taken action in reliance on this authorization or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac, [Attn: Policy Service, 1932 Wynnton Road, Columbus, GA 31999].

Unless otherwise revoked, I agree that this authorization will expire on the earlier of the date Aflac notifies me of its declination of my application for coverage or, if a policy is issued, two years from the policy effective date.

I agree that a copy of this authorization is as valid as the original.

For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

* hospitalization
* physician services
* hospice
* outpatient prescription drugs if you are enrolled in Medicare Part D
* other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

* Check the coverage in **all** health insurance policies you already have.
* For more information about Medicare and Medicare Supplement insurance, review the *Choosing a Medigap Policy:* A *Guide to Health Insurance for People with Medicare*, available from the insurance company.
* For help in understanding your health insurance, contact your state insurance department (website = www.accessarkansas.org/insurance) or state health insurance assistance program (SHIP Division of Department at 800-224-6330 or email *Insurance.Seniors@Arkansas.gov*).

Union

LUMP SUM CANCER INSURANCE POLICY (A72200 Series)
Supplemental Health Insurance Coverage

Application to: American Family Life Assurance Company of Columbus (Aflac)
[Worldwide Headquarters • Columbus, Georgia 31999]

❑ New
❑ Conversion
Policy Number:

Please Print in Black Ink – To Be Completed by Proposed Insured

Proposed Insured's Name _____
Last First MI

State of Birth_____ DOB _____ Sex _____
Month/Day/Year

SSN _____ - _____ - _____
(optional)

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP_____

Home Telephone (___)_____ Business Telephone (___)_____ Best Time to Call _____

E-Mail Address (optional)_____

Are you applying for Dependent Child(ren) coverage? ❑ Yes ❑ No
If Yes, Dependent Children must be under age 25 at the time of application.

Write spouse's name below if you are applying for Two-Parent Family or Named Insured/Spouse Only coverage; if you have no spouse or your spouse is not to be covered, put N/A in the space below.

Spouse's Name _____ DOB _____ Sex _____
Last First MI Month/Day/Year

Account Name_____ Account No._____

Name of Employer _____

Is this insurance intended to replace any other health insurance now in force? ❑ Yes ❑ No
If Yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable, and provide the policy number here: _____

Does anyone to be covered have any other Cancer coverage with Aflac? ❑ Yes ❑ No
If Yes, this must be a conversion of that coverage. Please give current policy number and see Applicant's Statements and Agreements concerning conversions.
Policy Number: _____

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Check Coverage Desired:	[❑ Individual	❑ Named Insured/ Spouse Only	❑ One-Parent Family	❑ Two-Parent Family

	Total No. Units	**Benefit Amount**	**Premium**	
❑ **Lump Sum Cancer Policy (Series A72200)** ***Total number of units are limited to [2 to 20] units at $5,000 per unit**				☒ After-Tax
Optional Rider:				
❑ **Return of Premium Benefit Rider (Series A72051)** **Options:** ❑ No Rider ❑ New Rider ❑ Retain Current Rider (Factor amt. _____)				
		Total Premium]		

Billing Method:
❑ Direct
❑ List Bill
❑ Bank Draft (B/D, ACH)
❑ Credit Card (C/C)

Mode:
❑ 01 Monthly
❑ 03 Quarterly
❑ 06 Semiannual
❑ 12 Annual

Assoc./Agent No. _____ Sit. Code _____ Billable Premium $ _____ Premium Collected $ _____

TO BE COMPLETED BY PROPOSED INSURED

Are you currently working at your primary job with the employer listed on the front of this application? ❑ Yes ❑ No

If you answered No to Question 1 above, a policy will not be issued; therefore, do not submit this application.

APPLICANT'S STATEMENTS AND AGREEMENTS:

- I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters. It is not the date I signed this application.
- I understand that the policy I am applying for will not cover any person who has attained age 71 before the Effective Date of the policy. The policy is guaranteed renewable to age 75. Coverage will terminate on the policy anniversary date following a Covered Person's 75th birthday.
- I understand that coverage is not provided for an illness, disease, infection, or disorder for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Loss caused by a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.
- I understand that unmarried Dependent Children, if any, must be under age 25 at the time of application. Once covered, Dependent Children will continue to be covered until the anniversary date of the policy following their 25th birthday.
- I acknowledge receipt of, if applicable:
  ❑ Replacement Notice ❑ Outline of Coverage
  ❑ *Guide To Health Insurance for People with Medicare*

- If this is an application for a conversion of coverage, the following conditions will apply: (1) If anyone covered under the previous policy is not eligible for coverage under the new policy, the policy for which this application is made for the person(s) identified will be void, and coverage will continue for this person only under the terms of the previous policy, if such policy remains in force; (2) The Time Limit on Certain Defenses provision will run from the Effective Date of the new policy, and the original policy will be terminated as of the Effective Date of the new policy; and (3) The Pre-existing Condition Limitations in the new policy will run from the original policy's Effective Date for the benefits provided under the original policy. For the increased benefit amount, the Pre-existing Condition Limitations in the new policy will run from the new policy's Effective Date.

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- If I am applying to replace existing Aflac coverage with this policy, I acknowledge that the policies may have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current Aflac policy and its benefits for the benefits provided in this Aflac policy.

  Proposed Insured's Initials _____

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- I understand that the purchase of this policy is intended to supplement my existing comprehensive health care coverage. It is not intended to replace or be issued in lieu of that coverage.

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I understand that any disclosure of health information to Aflac for the purpose of determining eligibility for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be re-disclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Aflac for enrollment or to determine eligibility for insurance or for underwriting or risk rating (where applicable) purposes and, should coverage be issued, the information may be used to contest a claim for benefits or the issuance of the policy itself during the contestability period provided in the policy.

I understand that Aflac is conditioning the issuance of coverage on the provision of this authorization, and that, while I may refuse to sign this authorization, my refusal to do so could result in coverage not being issued.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac has taken action in reliance on this authorization or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac, [Attn: Policy Service, 1932 Wynnton Road, Columbus, GA 31999].

Unless otherwise revoked, I agree that this authorization will expire on the earlier of the date Aflac notifies me of its declination of my application for coverage or, if a policy is issued, two years from the policy effective date.

I agree that a copy of this authorization is as valid as the original.

For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

* hospitalization
* physician services
* hospice
* outpatient prescription drugs if you are enrolled in Medicare Part D
* other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

* Check the coverage in **all** health insurance policies you already have.
* For more information about Medicare and Medicare Supplement insurance, review the *Choosing a Medigap Policy:* A *Guide to Health Insurance for People with Medicare*, available from the insurance company.
* For help in understanding your health insurance, contact your state insurance department (website = www.accessarkansas.org/insurance) or state health insurance assistance program (SHIP Division of Department at 800-224-6330 or email *Insurance.Seniors@Arkansas.gov*).

Payroll

Large Account

LUMP SUM CRITICAL ILLNESS INSURANCE POLICY (A72100 Series)
Supplemental Health Insurance Coverage

Application to: American Family Life Assurance Company of Columbus (Aflac)
[Worldwide Headquarters • Columbus, Georgia 31999]

❑ New
❑ Conversion
Policy Number:

Please Print in Black Ink – To Be Completed by Proposed Insured/Employee

Proposed Insured's/Employee's Name _____ _____ _____
Last First MI

State of Birth_____ DOB _____ Sex _____ Height _____ Weight _____
Month/Day/Year

SSN _____ - _____ - _____
(optional)

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP_____

Home Telephone (___)_____ Business Telephone (___)_____ Best Time to Call _____

E-Mail Address (optional)_____

Are you applying for Dependent Child(ren) coverage? ❑ Yes ❑ No
If Yes, Dependent Children must be under age 25 at the time of application.

Write spouse's name below if you are applying for Two-Parent Family or Named Insured/Spouse Only coverage; if you have no spouse or your spouse is not to be covered, put N/A in the space below.

Spouse's Name _____ _____ _____ DOB _____ Sex _____
Last First MI Month/Day/Year

Payroll Account Name_____ Payroll Account No._____

Name of Employer _____

Is this insurance intended to replace any other health insurance now in force? ❑ Yes ❑ No
If Yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable, and provide the policy number here: _____

Does anyone to be covered have any other Specified Health Event coverage with Aflac? ❑ Yes ❑ No
If Yes, this must be a conversion of that coverage. Please give current policy number and see Applicant's Statements and Agreements concerning conversions.
Policy Number: _____

Does anyone to be covered under the Lump Sum Cancer Benefit Rider have any other Cancer coverage with Aflac? ❑ Yes ❑ No ❑ N/A
If Yes, this must be a conversion of that coverage. Please give current policy number and see Applicant's Statements and Agreements concerning conversions.
Policy Number: _____

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Check Coverage Desired:	[❑ Individual	❑ Named Insured/ Spouse Only	❑ One-Parent Family	❑ Two-Parent Family

	Total No. Units	**Benefit Amount**	**Premium**	
❑ Lump Sum Critical Illness Policy (Series A72100) *Total number of units are limited to [2 to 20] units at $5,000 per unit				☒ After-Tax
Optional Riders:				
❑ Lump Sum Cancer Benefit Rider (Series A72050) **Internal Cancer Benefit Amount will be the same as the Major Critical Illness Event Benefit amount selected.**				
❑ Return of Premium Benefit Rider (Series A72051) Options: ❑ No Rider ❑ New Rider ❑ Retain Current Rider (Factor amt. _____)				
❑ Sudden Cardiac Death Benefit Rider (Series A72052) **Sudden Cardiac Death Benefit Amount will be the same as the Major Critical Illness Event Benefit amount selected.**				
		Total Premium]		

Billing Method:

❑ Payroll Deduction
❑ Bank Draft (B/D, ACH)
❑ Credit Card (C/C)

Mode:

❑ 01 Weekly
❑ 01 14-Day Biweekly
❑ 01 Semimonthly
❑ 01 28-Day Biweekly
❑ 01 Monthly
❑ 03 Quarterly
❑ 06 Semiannual
❑ 12 Annual

PLEASE NOTE: If B/D, ACH, or C/C billing method is checked, only the following modes of payment are available: Monthly, Quarterly, Semiannual, or Annual.

Employee No. _____ Dept. No. _____ Assoc./Agent's No. _____

Billable Premium $ _____ Premium Collected $ _____ Sit. Code _____

TO BE COMPLETED BY PROPOSED INSURED/EMPLOYEE

Has anyone to be covered used tobacco products or products containing nicotine of any type in the last 12 months? This information will be verified at the time of claim. ❑ Yes ❑ No

APPLICANT'S STATEMENTS AND AGREEMENTS:

- I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters. It is not the date I signed this application.
- I understand that the policy I am applying for will not cover any person who has attained age 71 before the Effective Date of the policy. The policy is guaranteed renewable to age 75. Coverage will terminate on the policy anniversary date following a Covered Person's 75th birthday.

- I understand that coverage is not provided for an illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Loss caused by a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.

- I understand that unmarried Dependent Children, if any, must be under age 25 at the time of application. Once covered, Dependent Children will continue to be covered until the anniversary date of the policy following their 25th birthday.

- I acknowledge receipt of, if applicable:
  - ❑ Replacement Notice
  - ❑ Outline of Coverage
  - ❑ *Guide To Health Insurance for People with Medicare*

- If this is an application for a conversion of coverage, the following conditions will apply: (1) If anyone covered under the previous policy is not eligible for coverage under the new policy, the policy for which this application is made for the person(s) identified will be void, and coverage will continue for this person only under the terms of the previous policy, if such policy remains in force; (2) The Time Limit on Certain Defenses provision will run from the Effective Date of the new policy, and the original policy will be terminated as of the Effective Date of the new policy; and (3) The Pre-existing Condition Limitations in the new policy will run from the original policy's Effective Date for the benefits provided under the original policy. For the increased benefit amount, the Pre-existing Condition Limitations in the new policy will run from the new policy's Effective Date.

- I understand that (1) the policy of insurance I am now applying for will be issued based upon the written answers to the questions and information asked for in this application and any other pertinent information Aflac may require for proper underwriting; (2) the policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (3) no change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.

- I understand that (1) Aflac is not bound by any statement made by me, or any associate/agent of Aflac, unless written herein and (2) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing.

- I understand that the premium amount listed on this application represents the premium amount that my employer will remit to Aflac on my behalf. I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me on an online enrollment system, if applicable.

- If I am applying to replace existing Aflac coverage with this policy, I acknowledge that the policies may have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current Aflac policy and its benefits for the benefits provided in this Aflac policy.

  Proposed Insured's Initials _____

- I have reviewed the statements and answers I have provided on this application. I understand that this policy is to be issued based upon these statements and answers, and any other pertinent information Aflac may require for proper underwriting. The answers are complete and true. I understand that all statements made in this application are deemed representations and not warranties but that material misrepresentations herein may result in loss of coverage under this policy. I further understand that I am signing this application one time even though I may have used it to apply for more than one policy. No person to be insured is covered by any Title XIX programs such as Medicaid.

- I understand that the purchase of this policy is intended to supplement my existing comprehensive health care coverage. It is not intended to replace or be issued in lieu of that coverage.

NOTICE OF INFORMATION PRACTICES

To issue an insurance policy, Aflac may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by Aflac may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you except information that relates to a claim or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our worldwide headquarters. This notice applies only in Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia.

INFORMATION REGARDING THE MEDICAL INFORMATION BUREAU (MIB) PRENOTICE

Information regarding your insurability will be treated as confidential. Aflac may, however, make a brief report thereon to MIB, Inc., formerly known as the Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB toll-free at [1-866-692-6901 (TTY 1-866-346-3642)]. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734].

Aflac may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its Web site at www.mib.com.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus (Aflac) or any person or entity acting on its part: any medical professional, medical care institution, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), MIB, Inc., formerly known as the Medical Information Bureau, consumer reporting agency, or employer.

"Information" means facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, driving record, or any other medical or nonmedical facts that Aflac deems appropriate to determine eligibility for insurance or to evaluate a claim for benefits during the time this authorization is valid. I also authorize Aflac to give information to MIB, Inc.

I understand that any disclosure of health information to Aflac for the purpose of determining eligibility for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be redisclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Aflac for enrollment or to determine eligibility for insurance or for underwriting or risk rating (where applicable) purposes and, should coverage be issued, the information may be used to contest a claim for benefits or the issuance of the policy itself during the contestability period provided in the policy.

I understand that Aflac is conditioning the issuance of coverage on the provision of this authorization, and that, while I may refuse to sign this authorization, my refusal to do so could result in coverage not being issued.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac has taken action in reliance on this authorization or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac, [Attn: Policy Service, 1932 Wynnton Road, Columbus, GA 31999].

Unless otherwise revoked, I agree that this authorization will expire on the earlier of the date Aflac notifies me of its declination of my application for coverage or, if a policy is issued, two years from the policy effective date.

I agree that a copy of this authorization is as valid as the original.

For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

* hospitalization
* physician services
* hospice
* outpatient prescription drugs if you are enrolled in Medicare Part D
* other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

* Check the coverage in **all** health insurance policies you already have.
* For more information about Medicare and Medicare Supplement insurance, review the *Choosing a Medigap Policy:* A *Guide to Health Insurance for People with Medicare*, available from the insurance company.
* For help in understanding your health insurance, contact your state insurance department (website = www.accessarkansas.org/insurance) or state health insurance assistance program (SHIP Division of Department at 800-224-6330 or email *Insurance.Seniors@Arkansas.gov*).

Payroll

Large Account

LUMP SUM CANCER INSURANCE POLICY (A72200 Series)
Supplemental Health Insurance Coverage
Application to: American Family Life Assurance Company of Columbus (Aflac)
[Worldwide Headquarters • Columbus, Georgia 31999]

❑ New
❑ Conversion
Policy Number:

Please Print in Black Ink – To Be Completed by Proposed Insured/Employee

Proposed Insured's/Employee's Name _____ _____ _____
Last First MI

State of Birth_____ DOB _____ Sex _____
Month/Day/Year

SSN. _____ - _____ - _____
(optional)

Address _____
Street or Post Office Box Apt. No.

City _____ State _____ ZIP_____

Home Telephone (___)_____ Business Telephone (___)_____ Best Time to Call _____

E-Mail Address (optional)_____

Are you applying for Dependent Child(ren) coverage? ❑ Yes ❑ No
If Yes, Dependent Children must be under age 25 at the time of application.

Write spouse's name below if you are applying for Two-Parent Family or Named Insured/Spouse Only coverage; if you have no spouse or your spouse is not to be covered, put N/A in the space below.

Spouse's Name _____ _____ _____ DOB _____ Sex _____
Last First MI Month/Day/Year

Payroll Account Name _____ Payroll Account No. _____

Name of Employer _____

Is this insurance intended to replace any other health insurance now in force? ❑ Yes ❑ No
If Yes, please read and sign the Replacement Notice provided by your associate/agent, if applicable, and provide the policy number here: _____

Does anyone to be covered have any other Cancer coverage with Aflac? ❑ Yes ❑ No
If Yes, this must be a conversion of that coverage. Please give current policy number and see Applicant's Statements and Agreements concerning conversions.
Policy Number: _____

TO BE COMPLETED BY AFLAC ASSOCIATE/AGENT

Check Coverage Desired:	[❑ Individual	❑ Named Insured/ Spouse Only	❑ One-Parent Family	❑ Two-Parent Family

	Total No. Units	**Benefit Amount**	**Premium**	
❑ **Lump Sum Cancer Policy (Series A72200)** ***Total number of units are limited to [2 to 20] units at $5,000 per unit**				☒ After-Tax
Optional Rider:				
❑ **Return of Premium Benefit Rider (Series A72051)** **Options:** ❑ No Rider ❑ New Rider ❑ Retain Current Rider (Factor amt. _____)				
		Total Premium]		

Billing Method:
- ❑ Payroll Deduction
- ❑ Bankdraft (B/D, ACH)
- ❑ Credit Card (C/C)

Mode:
- ❑ 01 Weekly
- ❑ 01 14-Day Biweekly
- ❑ 01 28-Day Biweekly
- ❑ 01 Semimonthly
- ❑ 01 Monthly
- ❑ 03 Quarterly
- ❑ 06 Semiannual
- ❑ 12 Annual

PLEASE NOTE: If B/D, ACH, or C/C billing method is checked, only the following modes of payment are available: Monthly, Quarterly, Semiannual, or Annual.

Employee No. _____ Dept. No. _____ Assoc./Agent's No. _____

Billable Premium $ _____ Premium Collected $ _____ Sit. Code _____

TO BE COMPLETED BY PROPOSED INSURED/EMPLOYEE

Has anyone to be covered used tobacco products or products containing nicotine of any type in the last 12 months? This information will be verified at the time of claim. ❑ Yes ❑ No

APPLICANT'S STATEMENTS AND AGREEMENTS:

- I understand that the Effective Date of the policy will be the date recorded in the Policy Schedule by Aflac Worldwide Headquarters. It is not the date I signed this application.
- I understand that the policy I am applying for will not cover any person who has attained age 71 before the Effective Date of the policy. The policy is guaranteed renewable to age 75. Coverage will terminate on the policy anniversary date following a Covered Person's 75th birthday.
- I understand that coverage is not provided for an illness, disease, infection, or disorder for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Loss caused by a Pre-existing Condition will not be covered unless it begins more than 12 months after the Effective Date of coverage.
- I understand that unmarried Dependent Children, if any, must be under age 25 at the time of application. Once covered, Dependent Children will continue to be covered until the anniversary date of the policy following their 25th birthday.
- I acknowledge receipt of, if applicable:
  - ❑ Replacement Notice
  - ❑ Outline of Coverage
  - ❑ *Guide To Health Insurance for People with Medicare*

- If this is an application for a conversion of coverage, the following conditions will apply: (1) If anyone covered under the previous policy is not eligible for coverage under the new policy, the policy for which this application is made for the person(s) identified will be void, and coverage will continue for this person only under the terms of the previous policy, if such policy remains in force; (2) The Time Limit on Certain Defenses provision will run from the Effective Date of the new policy, and the original policy will be terminated as of the Effective Date of the new policy; and (3) The Pre-existing Condition Limitations in the new policy will run from the original policy's Effective Date for the benefits provided under the original policy. For the increased benefit amount, the Pre-existing Condition Limitations in the new policy will run from the new policy's Effective Date.
- I understand that (1) the policy of insurance I am now applying for will be issued based upon the written answers to the questions and information asked for in this application and any other pertinent information Aflac may require for proper underwriting; (2) the policy, together with this application, endorsements, benefit agreements, riders, and attached papers, if any, constitutes the entire contract of insurance; and (3) no change to the policy will be valid until approved by Aflac's president and secretary, and noted in or attached to the policy.
- I understand that (1) Aflac is not bound by any statement made by me, or any associate/agent of Aflac, unless written herein and (2) the associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing.
- I understand that the premium amount listed on this application represents the premium amount that my employer will remit to Aflac on my behalf. I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me on an online enrollment system, if applicable.
- If I am applying to replace existing Aflac coverage with this policy, I acknowledge that the policies may have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current Aflac policy and its benefits for the benefits provided in this Aflac policy.

  Proposed Insured's Initials _____
- I have reviewed the statements and answers I have provided on this application. I understand that this policy is to be issued based upon these statements and answers, and any other pertinent information Aflac may require for proper underwriting. The answers are complete and true. I understand that all statements made in this application are deemed representations and not warranties but that material misrepresentations herein may result in loss of coverage under this policy. I further understand that I am signing this application one time even though I may have used it to apply for more than one policy. No person to be insured is covered by any Title XIX programs such as Medicaid.
- I understand that the purchase of this policy is intended to supplement my existing comprehensive health care coverage. It is not intended to replace or be issued in lieu of that coverage.

NOTICE OF INFORMATION PRACTICES

To issue an insurance policy, Aflac may need to obtain additional information about you and any other persons proposed for insurance. Some information will come from you and some may come from other sources. That information and any other subsequent information collected by Aflac may in some circumstances be disclosed to third parties without your specific consent. You have the right to access and correct the information collected about you except information that relates to a claim or to a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please submit a written request to our worldwide headquarters. This notice applies only in Arizona, California, Connecticut, Georgia, Illinois, Maine, Massachusetts, Minnesota, Nevada, New Jersey, North Carolina, Ohio, Oregon, and Virginia.

INFORMATION REGARDING THE MEDICAL INFORMATION BUREAU (MIB)
PRENOTICE

Information regarding your insurability will be treated as confidential. Aflac may, however, make a brief report thereon to MIB, Inc., formerly known as the Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB toll-free at [1-866-692-6901 (TTY 1-866-346-3642)]. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734].

Aflac may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its Web site at www.mib.com.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize the following to give information (as defined below) to American Family Life Assurance Company of Columbus (Aflac) or any person or entity acting on its part: any medical professional, medical care institution, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), MIB, Inc., formerly known as the Medical Information Bureau, consumer reporting agency, or employer.

"Information" means facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, driving record, or any other medical or non-medical facts that Aflac deems appropriate to determine eligibility for insurance or to evaluate a claim for benefits during the time this authorization is valid. I also authorize Aflac to give information to MIB, Inc.

I understand that any disclosure of health information to Aflac for the purpose of determining eligibility for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be re-disclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Aflac for enrollment or to determine eligibility for insurance or for underwriting or risk rating (where applicable) purposes and, should coverage be issued, the information may be used to contest a claim for benefits or the issuance of the policy itself during the contestability period provided in the policy.

I understand that Aflac is conditioning the issuance of coverage on the provision of this authorization, and that, while I may refuse to sign this authorization, my refusal to do so could result in coverage not being issued.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac has taken action in reliance on this authorization or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Aflac, [Attn: Policy Service, 1932 Wynnton Road, Columbus, GA 31999].

Unless otherwise revoked, I agree that this authorization will expire on the earlier of the date Aflac notifies me of its declination of my application for coverage or, if a policy is issued, two years from the policy effective date.

I agree that a copy of this authorization is as valid as the original.

For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

* hospitalization
* physician services
* hospice
* outpatient prescription drugs if you are enrolled in Medicare Part D
* other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

* Check the coverage in **all** health insurance policies you already have.
* For more information about Medicare and Medicare Supplement insurance, review the *Choosing a Medigap Policy:* A *Guide to Health Insurance for People with Medicare*, available from the insurance company.
* For help in understanding your health insurance, contact your state insurance department (website = www.accessarkansas.org/insurance) or state health insurance assistance program (SHIP Division of Department at 800-224-6330 or email *Insurance.Seniors@Arkansas.gov*).

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)

[Worldwide Headquarters: 1932 WYNNTON ROAD, COLUMBUS, GEORGIA 31999
TOLL-FREE 1-800-99-AFLAC (1-800-992-3522)]

The policy described in this Outline of Coverage provides supplemental coverage and will be issued only to supplement insurance already in force.

LIMITED BENEFIT, LUMP SUM CRITICAL ILLNESS INSURANCE
Outline of Coverage for Policy Form Series A72100
THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.

If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide furnished by Aflac.

(1) Read Your Policy Carefully: This Outline of Coverage provides a very brief description of some of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and Aflac. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

(2) Lump Sum Critical Illness Insurance Coverage is designed to supplement your existing accident and sickness coverage only when certain losses occur as a result of Critical Illness Events. Critical Illness Events are: Heart Attack, Stroke, Major Human Organ Transplant, End-Stage Renal Failure, Paralysis, or Coma. Coverage is provided for the benefits outlined in Part (3). The benefits described in Part (3) may be limited by Part (5).

(3) Benefits: Subject to the Pre-existing Condition Limitations, Limitations and Exclusions, and all other policy provisions, we will pay the following benefits for a covered Critical Illness Event that occurs while coverage is in force.

For any benefit to be payable, the Onset Date of the Loss must occur on or after the Effective Date of coverage and while coverage is in force. If more than one Loss per Covered Person occurs on the same day, only the highest eligible benefit will be paid. Aflac will not accept an assignment of these benefits. All benefits will be payable to you. Any accrued benefits unpaid at your death will be paid to your estate.

A. MAJOR CRITICAL ILLNESS EVENT BENEFIT: Aflac will pay [$ _____] upon a Covered Person's Onset Date of any of the following Critical Illness Events:

1) Heart Attack
2) Stroke
3) End-Stage Renal Failure
4) Coma
5) Paralysis
6) Major Human Organ Transplant

After qualifying for this benefit, such Covered Person will again become eligible for this benefit after five years from the later of (1) the Onset Date of any Critical Illness Event of such Covered Person or (2) the latest hospitalization or surgery due to such Covered Person's Critical Illness Event. No lifetime maximum.

B. SUBSEQUENT CRITICAL ILLNESS EVENT BENEFIT: After a Covered Person has previously qualified for benefits under Benefit A above, Aflac will pay $5,000 upon that Covered Person's Onset Date of:

1) a **recurrence** of that **same** Critical Illness Event or
2) an occurrence of a **different** Critical Illness Event.

For this benefit to be payable, the Onset Date of the Critical Illness Event must be 180 days or more from the Onset Date of any previously paid Critical Illness Event for such Covered Person. This benefit is not payable on the same day as the Major Critical Illness Event Benefit. No lifetime maximum.

C. CORONARY ARTERY BYPASS GRAFT SURGERY BENEFIT: Aflac will pay $3,000 when a Covered Person undergoes Coronary Artery Bypass Graft Surgery. This benefit is payable once per Covered Person, per lifetime.

(4) Optional Benefits:

LUMP SUM CANCER BENEFIT RIDER: (Series A72050) Applied for ❑ Yes ❑ No

This rider is issued on the basis that the information shown on the application is correct and complete. If any answers on your application for this rider are incorrect or incomplete, the benefits under this rider will be the lesser of the benefits that you would have been eligible to purchase if a correct or complete answer had been given or your original rider benefit amount. Any overpayment of premium will be refunded to you, less any claims paid.

While this coverage is in force, we will pay the following benefits, as applicable, subject to the Pre-existing Condition Limitations, Limitations and Exclusions, and all other policy provisions unless modified herein.

For benefits to be payable, the Onset Date of the Loss must occur on or after the Effective Date of coverage, while coverage is in force, and must be separated by 180 days or more from the Onset Date of any other covered Loss. If more than one Loss per Covered Person occurs within 180 days, only the highest eligible benefit will be paid. Aflac will not accept an assignment of these benefits. All benefits will be payable to you. Any accrued benefits unpaid at your death will be paid to your estate.

A. INTERNAL CANCER BENEFIT: Aflac will pay [$_____] upon a Covered Person's Onset Date of Internal Cancer. This benefit is payable once per Covered Person, per lifetime.

B. CARCINOMA IN SITU BENEFIT: Aflac will pay $2,000 upon a Covered Person's Onset Date of Carcinoma In Situ. This benefit is payable once per Covered Person, per lifetime.

C. CANCER-RELATED DEATH BENEFIT: Aflac will pay $5,000 when a Covered Person suffers a Cancer-Related Death.

Exceptions, Reductions and Limitations of Rider A72050 Series:

A. Benefits are not provided for premalignant conditions or conditions with malignant potential (unless specifically covered); complications of cancer; or any other disease, sickness, or incapacity. Aflac will not pay benefits for recurrence, direct extension, or metastatic spread of any cancer diagnosed prior to the Effective Date of coverage.

B. Aflac will not pay benefits for any Loss that is caused by a Pre-existing Condition unless the Onset Date is more than 12 months after the Effective Date of coverage. Benefits are payable for only one covered Loss at a time per Covered Person.

C. Aflac will not pay benefits for a Loss that is diagnosed outside the territorial limits of the United States, its possessions, or the countries of Canada and Mexico.

D. Aflac will not pay benefits whenever coverage provided by this rider is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

E. For benefits to be payable, the Onset Date must occur on or after the Effective Date of coverage, while coverage is in force and must be separated by 180 days or more from the Onset Date of any other covered Loss. If more than one Loss per Covered Person occurs within 180 days, only the highest eligible benefit will be paid.

F. Aflac will not pay benefits for Skin Cancers.

RETURN OF PREMIUM BENEFIT: (Series A72051) Applied for ❑ Yes ❑ No

Aflac will pay you a cash value based upon the annualized premium paid for this rider, the policy, and any other attached benefit riders **(premium paid for the policy and other attached benefit riders will be calculated at the original premium in effect on the rider Effective Date and will not include premium increases that may occur for the policy or other such riders)**. All Return of Premium Benefits/cash values paid will be less any claims paid. If you surrender this rider for its cash value after the Onset Date of a Loss but before claims are submitted, we will reduce subsequent claim payment(s) by the amount of the cash value paid. Both the policy and the rider must remain in force for 20 consecutive years for you to obtain a maximum refund of premiums paid.

The cash value for premium paid for the policy and rider begins on the fifth rider anniversary date.

Your cash value is based upon annualized premium of **xxxxxxx**. If you surrender this rider after its fifth anniversary and such surrender occurs between rider anniversaries, a prorated amount for the partial year will be paid. The proration will be calculated by taking the cash value difference between the last and next anniversary dates, dividing by 12, and multiplying by the number of months that premiums were earned in the partial year at the time of surrender. This proration will then be added to the cash value on the last rider anniversary date, and this will be the cash value paid.

IMPORTANT! READ CAREFULLY: This rider will terminate on the earlier of: its 20th anniversary date and payment of the cash value; your surrender of it for its cash value between the fifth and 20th anniversary dates; your death prior to its 20th anniversary date, in which case the cash value (if any) will be paid to your estate; your failure to pay the premium for this rider, in which case any cash values due will be paid; the policy's termination, in which case any cash values due will be paid; or the time that claims paid equal or exceed the cash value that would be paid on the 20th policy anniversary. When this rider terminates (is no longer in force), no further premium will be charged for it.

SUDDEN CARDIAC DEATH BENEFIT RIDER: (Series A72052) Applied for ❑ Yes ❑ No

While this coverage is in force, we will pay the following benefit, as applicable, subject to the Pre-existing Condition Limitations, Limitations and Exclusions, and all other policy provisions unless modified herein.

For benefits to be payable, the Onset Date must occur on or after the Effective Date of coverage, while coverage is in force, and must be separated by 180 days or more from the Onset Date of any previously paid Critical Illness Event for such Covered Person. If Sudden Cardiac Death occurs within 180 days of a Critical Illness Event for the same Covered Person, only the highest eligible benefit will be paid. If Coronary Artery Bypass Graft Surgery and Sudden Cardiac Death occur on the same day, only the highest eligible benefit will be paid. Aflac will not accept an assignment of these benefits. All benefits will be payable to you or your estate.

A. SUDDEN CARDIAC DEATH BENEFIT: Aflac will pay [$_____] upon a Covered Person's Onset Date of Sudden Cardiac Death. This benefit is payable once per Covered Person, per lifetime.

(5) Exceptions, Reductions and Limitations of the Policy (This is not a daily hospital expense plan.):

A. Aflac will not pay benefits for any Loss that is caused by a Pre-existing Condition unless it begins more than 12 months after the Effective Date of coverage. Benefits are payable for only one covered Loss at a time per Covered Person.

B. Aflac will not pay benefits for any event that is diagnosed or treated outside the territorial limits of the United States, its possessions, or the countries of Canada and Mexico.

C. Aflac will not pay benefits whenever coverage provided by this policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

D. For any benefit to be payable, the Onset Date of the Loss must occur on or after the Effective Date of coverage and while coverage is in force. If more than one Loss per Covered Person occurs on the same day, only the highest eligible benefit will be paid.

E. This policy does not cover Loss caused by or resulting from:

1. Using any drug, narcotic, hallucinogen, or chemical substance (unless administered by a Physician and taken according to the Physician's instructions) or voluntarily taking any kind of poison or inhaling any kind of gas or fumes;
2. Participating in, or attempting to participate in, an illegal activity that is defined as a felony, whether charged or not ("felony" is as defined by the law of the jurisdiction in which the activity takes place); or being incarcerated in any type penal institution;
3. Intentionally self-inflicting a bodily injury or committing or attempting suicide, while sane or insane;
4. Being exposed to war or any act of war, declared or undeclared;
5. Actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Reserve;

A Pre-existing Condition is an illness, disease, infection, disorder, or injury for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Benefits for a Loss that is caused by a Pre-existing Condition will not be covered unless the Onset Date is more than 12 months after the Effective Date of coverage.

(6) Renewability: The policy is guaranteed-renewable to age 75 by payment of the premium in effect at the beginning of each renewal period. Premium rates may change only if changed on all policies of the same form number and class in force in your state. **Coverage under the policy will terminate on the policy anniversary date following a Covered Person's 75th birthday.**

RETAIN FOR YOUR RECORDS.
THIS OUTLINE OF COVERAGE IS ONLY A BRIEF SUMMARY OF THE COVERAGE PROVIDED.
THE POLICY ITSELF SHOULD BE CONSULTED TO DETERMINE
GOVERNING CONTRACTUAL PROVISIONS.

AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)

[Worldwide Headquarters: 1932 WYNNTON ROAD, COLUMBUS, GEORGIA 31999
TOLL-FREE 1-800-99-AFLAC (1-800-992-3522)]

The policy described in this Outline of Coverage provides supplemental coverage and will be issued only to supplement insurance already in force.

LIMITED BENEFIT, LUMP SUM CANCER INSURANCE
Outline of Coverage for Policy Form Series A72200
THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.

If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide furnished by Aflac.

(1) Read Your Policy Carefully: This Outline of Coverage provides a very brief description of some of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and Aflac. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

(2) Lump Sum Cancer Insurance Coverage is designed to supplement your existing accident and sickness coverage only when certain losses occur as a result of cancer. Coverage is provided for the benefits outlined in Part (3). The benefits described in Part (3) may be limited by Part (5).

(3) Benefits: Subject to the Pre-existing Condition Limitations, Limitations and Exclusions, and all other policy provisions, we will pay the following benefits for a covered cancer that occurs while coverage is in force.

For benefits to be payable, the Onset Date of the Loss must occur on or after the Effective Date of coverage, while coverage is in force, and must be separated by 180 days or more from the Onset Date of any other covered Loss for such Covered Person. If more than one Loss per Covered Person occurs within 180 days, only the highest eligible benefit will be paid. Aflac will not accept an assignment of these benefits. All benefits will be payable to you. Any accrued benefits unpaid at your death will be paid to your estate.

A. INTERNAL CANCER BENEFIT: Aflac will pay [$_____] upon a Covered Person's Onset Date of Internal Cancer. This benefit is payable once per Covered Person, per lifetime.

B. CARCINOMA IN SITU BENEFIT: Aflac will pay $2,000 upon a Covered Person's Onset Date of Carcinoma In Situ. This benefit is payable once per Covered Person, per lifetime.

C. CANCER-RELATED DEATH BENEFIT: Aflac will pay $5,000 when a Covered Person suffers a Cancer-Related Death.

(4) Optional Benefits:

RETURN OF PREMIUM BENEFIT: (Series A72051) Applied for ❑ Yes ❑ No

Aflac will pay you a cash value based upon the annualized premium paid for this rider, the policy, and any other attached benefit riders **(premium paid for the policy and other attached benefit riders will be calculated at the original premium in effect on the rider Effective Date and will not include premium increases that may occur for the policy or other such riders)**. All Return of Premium Benefits/cash values paid will be less any claims paid. If you surrender this rider for its cash value after the Onset Date of a Loss but before claims are submitted, we will reduce subsequent claim payment(s) by the amount of the cash

value paid. Both the policy and the rider must remain in force for 20 consecutive years for you to obtain a maximum refund of premiums paid.

The cash value for premium paid for the policy and rider begins on the fifth rider anniversary date.

Your cash value is based upon annualized premium of **xxxxxxx**. If you surrender this rider after its fifth anniversary and such surrender occurs between rider anniversaries, a prorated amount for the partial year will be paid. The proration will be calculated by taking the cash value difference between the last and next anniversary dates, dividing by 12, and multiplying by the number of months that premiums were earned in the partial year at the time of surrender. This proration will then be added to the cash value on the last rider anniversary date, and this will be the cash value paid.

IMPORTANT! READ CAREFULLY: This rider will terminate on the earlier of: its 20th anniversary date and payment of the cash value; your surrender of it for its cash value between the fifth and 20th anniversary dates; your death prior to its 20th anniversary date, in which case the cash value (if any) will be paid to your estate; your failure to pay the premium for this rider, in which case any cash values due will be paid; the policy's termination, in which case any cash values due will be paid; or the time that claims paid equal or exceed the cash value that would be paid on the 20th policy anniversary. When this rider terminates (is no longer in force), no further premium will be charged for it.

(5) Exceptions, Reductions and Limitations of the Policy (This is not a daily hospital expense plan.):

A. Benefits are not provided for premalignant conditions or conditions with malignant potential (unless specifically covered); complications of cancer; or any other disease, sickness, or incapacity. Aflac will not pay benefits for recurrence, direct extension, or metastatic spread of any cancer diagnosed prior to the Effective Date of coverage.

B. Aflac will not pay benefits for any Loss that is caused by a Pre-existing Condition unless the Onset Date is more than 12 months after the Effective Date of coverage. Benefits are payable for only one covered Loss at a time per Covered Person.

C. Aflac will not pay benefits for a Loss that is diagnosed outside the territorial limits of the United States, its possessions, or the countries of Canada and Mexico.

D. Aflac will not pay benefits whenever coverage provided by this policy is in violation of any U.S. economic or trade sanctions. If the coverage violates U.S. economic or trade sanctions, such coverage shall be null and void.

E. For benefits to be payable, the Onset Date must occur on or after the Effective Date of coverage, while coverage is in force and must be separated by 180 days or more from the Onset Date of any other covered Loss. If more than one Loss per Covered Person occurs within 180 days, only the highest eligible benefit will be paid.

F. Aflac will not pay benefits for Skin Cancers.

A Pre-existing Condition is an illness, disease, infection, or disorder for which, within the 12-month period before the Effective Date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Benefits for a Loss that is caused by a Pre-existing Condition will not be covered unless the Onset Date is more than 12 months after the Effective Date of coverage.

(6) Renewability: The policy is guaranteed-renewable to age 75 by payment of the premium in effect at the beginning of each renewal period. Premium rates may change only if changed on all policies of the same form number and class in force in your state. **Coverage under the policy will terminate on the policy anniversary date following a Covered Person's 75th birthday.**

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THE POLICY ITSELF SHOULD BE CONSULTED TO DETERMINE
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